PATIENT INFORMATION SHEET

Patient/client:

Last name:________________________ First:___________________________ Middle:_____

Address:____

City:____ State:_______ Zip Code: ___________

Date of birth:_________________ Soc. Sec. #______________________ Age: _____________

Sex: ☐Male ☐Female Marital status: ☐Single ☐Married ☐Sep ☐Div ☐Widowed ☐Other

Check the box next to number(s) where you give us permission to leave message(s) for you:

☐Home phone: _________________________ ☐Work phone: __________________________

☐Cell phone: _________________________ ☐Other phone: __________________________

Email address: _________________________ Pager: __________________________

Employment status: ☐Full-time ☐Part-time ☐Unemployed ☐Disabled

Employer: ____

Student status: ☐Non-student ☐Full-time student ☐Part-time student

School:____ Grade: ____________________

Pharmacy: __________________ Location:_____________ Phone # _____________________

Referred by:____

Person responsible for payment (Guarantor):

Last name:________________________ First:___________________________ Middle:_____

Address:____

City:____ State:_______ Zip Code: ___________

Date of birth:_________________ Soc. Sec. #______________________ Age: _____________

Sex: ☐Male ☐Female Marital status: ☐Single ☐Married ☐Sep ☐Div ☐ Widowed ☐Other

Home phone: ___________________________ Work phone: __________________________

Cell phone: ___________________________ Other phone: __________________________

Email address: _________________________ Pager: __________________________

Employment status: ☐Full-time ☐Part-time ☐Unemployed ☐Disabled

Employer: ____

Student status: ☐Non-student ☐Full-time student ☐Part-time student

Next of kin:

Name:_____________________________

Address:___________________________

____

Tel. # ____________________________

Relationship to patient: ______________

Person to notify in case of emergency:

Name:_____________________________

Address:___________________________

____

Tel. # ____________________________

Relationship to patient: ______________

Primary Insurance:

Name of insurance: ____

Policy # ____________________________________ Group # _________________________

Subscriber name: _________________________________ Subscriber ID # ________________

Plan type: ☐HMO ☐PPO ☐POS ☐Traditional

Secondary Insurance:

Name of insurance: ____

Policy # ____________________________________ Group # _________________________

Subscriber name: _________________________________ Subscriber ID # ________________

Plan type: ☐HMO ☐PPO ☐POS ☐Traditional

I certify that the above information is complete and accurate.

____ ____________________

Patient or Parent/guardian Date