



## Patient Insurance Information Form

### Patient's Personal Information

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Email Address \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Employer Information

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Work Phone # \_\_\_\_\_

### Patient's/Responsible Party Information

Relationship to Patient ( ) Self ( ) Spouse ( ) Child ( ) Other \_\_\_\_\_  
 Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Email Address \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

### Primary Insurance

Primary Insurance Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Name of the Insured \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Policy # \_\_\_\_\_ Group \_\_\_\_\_ Co-pay \_\_\_\_\_  
 Relationship to Insured ( ) Self ( ) Spouse ( ) Child ( ) Other \_\_\_\_\_

### Secondary Insurance

Secondary Insurance Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Name of the Insured \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Policy # \_\_\_\_\_ Group \_\_\_\_\_ Co-pay \_\_\_\_\_  
 Relationship to Insured ( ) Self ( ) Spouse ( ) Child ( ) Other \_\_\_\_\_

### Patient's Referral Information

Referred by \_\_\_\_\_ Phone ( ) \_\_\_\_\_

### Patient's Primary Medical Doctor

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_



**Pharmacy Information**

Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone # \_\_\_\_\_