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**PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION**

PLEASE COMPLETE AND RETURN TO US WITH YOUR MEDICAL HISTORY FORM

DATE OF APPOINTMENT: \_\_\_\_\_

NAME: \_\_\_\_\_

(please enter name as it appears on your insurance card)

ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ GENDER: MALE / FEMALE (please circle)

RACE: \_\_\_\_\_ ETHNICITY: Not of Spanish/Hispanic Origin / Spanish-Hispanic Origin  
(please circle one)

HOME PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ EXT \_\_\_\_\_

EMAIL: \_\_\_\_\_

PHARMACY NAME / LOCATION / PHONE #:  
\_\_\_\_\_

PCP: \_\_\_\_\_

REFERRING PHYSICIAN (if applicable): \_\_\_\_\_

NAME OF INSURANCE SUBSCRIBER: \_\_\_\_\_

DATE OF BIRTH OF INSURANCE SUBSCRIBER: \_\_\_\_\_

RELATIONSHIP TO INSURANCE SUBSCRIBER: \_\_\_\_\_

ADDRESS OF SUBSCRIBER: \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_

PRIMARY INSURANCE ID #: \_\_\_\_\_ GROUP/PLAN #: \_\_\_\_\_

IF APPLICABLE:

SECONDARY INSURANCE: \_\_\_\_\_

SECONDARY INSURANCE ID #: \_\_\_\_\_ GROUP/PLAN #: \_\_\_\_\_