RETURN

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: ____________________ First Name: __________________ MI: ___ Date of Birth:_______________

Social Security Number ___________________________ Address: ______________________________________

(apt#, lot#, etc.) _____________ City:________________________ State: ______Zip:____________

Male___ Female____ Facility Name (if applicable)___________________________

Home Phone: (_____)_______________________________ Cell Phone :(_____)____________________

Spouse's Name: _________________________Date of Birth: _____________ Spouse's SS# _______________

Race: American Indian or Alaska native Asian Black or African American

Native Hawaiian or other Pacific Islander White Unknown/Declined to answer

Do you have a dog? ____Yes _____No **Would you like access to patient portal? ___Yes No___**

Email address for patient portal_________________

How would you like appointment reminders? Call___ Text____ Both Call and Text______

Cell number for reminder_____________

RESPONSIBLE PARTY: THIS SECTION REFERS TO THE PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Relationship to Patient: ______ Self (skip to next section) ______ Spouse Other: ___________________

Last Name: __________________________________ First Name: ____________________________ MI: _____

Address: ______________________________ City: _____________________ State: _____ Zip: _____________

Home Phone: ( ) _______________ Cell Phone: ( ) _____________ Work Phone: ( ) ________________

INSURANCE INFORMATION

Primary Insurance Coverage _______________________________________ Effective Date: _________________

Address: __________________________________ City: _____________________ State: ______ Zip: __________

Phone Number :( ) __________ Policy Number: ________________________ Group Number: __________

Subscriber: ______________________Subscriber's DOB_______________ Subscriber's SS# _________________

Secondary Insurance Coverage: ____

Address: __________________________________ City: _________________ State: ______ Zip: _____________

Phone Number: ( ) ____________________ Policy Number: ______________ Group Number:__________

Subscriber: _____________________ Subscriber's DOB _________________ Subscriber's SS# ________________

OTHER INFORMATION

Pharmacy – Local ____________________________ Address: ______________________________________

Phone:________________________________ Pharmacy–Mail Order_________________________

Address: _____________________________________ Phone: ________________________________

Referred by __________________ Verified Information _______ Staff Initials: ___________