

## Basic Information

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Full Name \_\_\_\_\_  
First Middle Last Suffix

Sex  Male  Female  Unknown Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Primary Phone  Home  Mobile  Work Phone Number \_\_\_\_\_

Email \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address Line 1 \_\_\_\_\_ Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status \_\_\_\_\_ Maiden Last \_\_\_\_\_

Driver's License State \_\_\_\_\_ Driver's License # \_\_\_\_\_

## Demographics

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Sexual Orientation \_\_\_\_\_ Gender Identity \_\_\_\_\_

Hispanic or Latino?  Yes  No  Decline to Specify Ethnicity \_\_\_\_\_

Race \_\_\_\_\_ Language \_\_\_\_\_

## Emergency Contact

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Relationship to Contact \_\_\_\_\_

Full Name \_\_\_\_\_  
First Middle Last

Primary Phone  Home  Mobile  Work Phone Number \_\_\_\_\_

Email \_\_\_\_\_

Address Line 1 \_\_\_\_\_ Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Financial Information

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### Responsible Party

Who will be financially responsible for you?  Myself  Someone else

*If you chose "Someone Else", please fill out the following:*

Relationship to Contact \_\_\_\_\_

Full Name \_\_\_\_\_

First

Middle

Last

Primary Phone  Home  Mobile  Work

Phone Number \_\_\_\_\_

### Method of Payment

What will be your method of payment?  Insurance  Self-Pay

*If you chose "Insurance", please fill out the following:*

#### PRIMARY INSURANCE POLICY

Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Insurance Plan \_\_\_\_\_

Insurance Phone Number \_\_\_\_\_

Group Number \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Relationship to Primary Policy Holder \_\_\_\_\_

*If you are not the primary policy holder, please fill out the following:*

Full Name \_\_\_\_\_

First

Middle

Last

Sex  Male  Female  Unknown

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Policy ID Number \_\_\_\_\_

Social Security Number \_\_\_\_\_

Policy Holder Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

If you are unable to provide your insurance information, please provide a reason before continuing.

**SECONDARY INSURANCE POLICY**

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Insurance Plan \_\_\_\_\_ Insurance Phone Number \_\_\_\_\_

Group Number \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Secondary Policy Holder \_\_\_\_\_

If you are not the secondary policy holder, please fill out the following:

Full Name \_\_\_\_\_  
First Middle Last

Sex  Male  Female  Unknown

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insurance ID Number \_\_\_\_\_

Social Security Number \_\_\_\_\_

Policy Holder Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

**Additional Information**

Please list your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address

How did you hear about us? \_\_\_\_\_