

PATIENT INFORMATION	Please present your insurance card and a photo ID at time of check-ir
Patient's Name : Last	First Gender: M / F
Social Security Number :	Date of Birth : (mm/dd/yy)
	APT City State Zip Code
Mobile#	Work# 🔠
Email Address 💭	Occupation :
Race: Ethnicity:	
Alternative contact : Name: Phor	ne: Relationship:
Pharmacy Name :	Phone :
Address: Street Address	APT City State Zip Code
Primary Care Doctor Name :	Phone :
Address: Street Address	APT City State Zip Code
Please list any medical problems :	
Please list any medications you are allergic to:	
Please list any medications you are taking :	
Please list any family history of diseases or conditions :	
Smoking Status: Current Smoker Former Sm IF YOU DO NOT HAVE YOUR INSURANCE CA	
PRIMARY INSURANCE	SECONDARY INSURANCE
Company Name :	Company Name :
Relationship to Policy Holder:	Relationship to Policy Holder :
Self Spouse Child Domestic Partner	Self Spouse Child Domestic Partner
Policy Holder's Name :	Policy Holder's Name :
Social Security Number :	Social Security Number :
Date of Birth: Gender: M / F	Date of Birth: Gender: M / F
REASON FOR VISIT	
Please check one of the following:	
☐ Employment related injury ☐ Motor Vehicle Acc	cident
HOW DID YOU HEAR ABOUT US	
☐ Google ☐ Yahoo ☐ Bing ☐ Subway ☐ Other(Please Specify) :	·
LLC Harrist Madical Comp. T 740, 473, 5000 5 LIC	