

**EMERGENCY CONTACT:**

Name \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ 2<sup>nd</sup> Phone \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary

Insurance Name \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Address: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Policy Holder's SS# \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_\_

Secondary

Insurance Name \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Address: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Policy Holder's SS# \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_\_

**PREFERRED PHARMACY:**

Name: \_\_\_\_\_ Phone \_\_\_\_\_

**Privacy Information (Required)**

May we call the telephone number listed and leave a message on an answering machine or with a family member with any appointments or results of tests performed? Yes  No

Do you currently have an Advanced Directive or Living Will? Yes  No

Do you currently have a Power of Attorney? Yes  No

Do you wish to share information regarding your health with a family member or friend? Yes  No

Please name the person(s): \_\_\_\_\_