



Date ____/____/____

First Name _____ Middle Initial ____ Last Name _____

Date of Birth ____/____/____ Social Security Number ____-____-____

Gender identity (circle one): Male Female Non-binary Transgender Prefer Not to Say

Assigned sex at birth (circle one): Male Female

Pronouns (circle one): he/him she/her they/them

Relationship Status (circle one):

Married Partnered Single Divorced Separated Widow/Widower

Mailing Address _____ Apartment/Suite _____

Physical Address _____ Apartment/Suite _____

City _____ State _____ Zip Code _____

Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Race _____ Ethnicity _____ Primary Language _____

Employment Status (circle one):

Employed Self Employed Unemployed Disabled Retired Student

Occupation _____ Employer _____

Emergency Contact _____ Relation _____

Phone _____

Pharmacy (circle one)

Safeway, Burns Rite Aid, Hines Access Prime Pharmacy Other _____

Insurance Information – only fill out if you do not provide us with your insurance cards

Primary Insurance Information

Name of Insurance Company _____ Phone _____

ID/Subscriber Number _____ Group Number _____

Subscriber Name _____ Relationship to Patient _____

Subscriber SSN ____-____-____ Subscriber DOB ____/____/____

Secondary Insurance Information (if applicable)

Name of Insurance Company _____ Phone _____

ID/Subscriber Number _____ Group Number _____

Subscriber Name _____ Relationship to Patient _____

Subscriber SSN ____-____-____ Subscriber DOB ____/____/____