



<b>PATIENT DEMOGRAPHIC INFORMATION</b>			
Patient's Legal Name (First, Middle Initial, Last)		Social Security Number	Date of Birth (Month, Day, Year)
Preferred First Name:	Maiden Name:		Gender at Birth: Male <input type="checkbox"/> Female <input type="checkbox"/>
Physical Address:  Mailing Address:	City:	State:	Zip Code:
Marital Status: Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/>		Email Address:	
Secondary Phone:	Preferred Pharmacy (Name & Town)		
Does the patient have any problems with: Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Reading <input type="checkbox"/> Speaking <input type="checkbox"/> Please Explain for any boxes checked:			

<b>PERSON(S) WHO MAY BE NOTIFIED IN CASES OF EMERGENCY OTHER THAN PARENT/LEGAL GUARDIAN</b>		
This does not give the individual(s) listed authority to accompany minor to appointment or access medical records.		
Name:	Phone Number:	Relationship to Patient:
Name:	Phone Number:	Relationship to Patient:
Name:	Phone Number:	Relationship to Patient:
Name:	Phone Number:	Relationship to Patient:

**MEDICAL INSURANCE INFORMATION**

**Please provide a copy of ALL insurance cards**

<b>Primary Medical Insurance</b>	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> BCBS/Anthem <input type="checkbox"/> Tricare <input type="checkbox"/> Other:		
	Insurance Name:		
	Subscriber Name:	Subscriber DOB:	Subscribe Phone Number:
	Subscriber Number:	Group Number:	Relationship to Patient:
<b>Secondary Medical Insurance</b>	Insurance Name:		
	Subscriber Name:	Subscriber DOB:	Subscribe Phone Number:
	Subscriber Number:	Group Number:	Relationship to Patient:

**DENTAL INSURANCE INFORMATION**

**Please provide a copy of ALL insurance cards**

<b>Primary Dental Insurance</b>	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> BCBS/Anthem <input type="checkbox"/> Tricare <input type="checkbox"/> Other:		
	Insurance Name:		
	Subscriber Name:	Subscriber DOB:	Subscribe Phone Number:
	Subscriber Number:	Group Number:	Relationship to Patient:
<b>Secondary Dental Insurance</b>	Insurance Name:		
	Subscriber Name:	Subscriber DOB:	Subscribe Phone Number:
	Subscriber Number:	Group Number:	Relationship to Patient:

<b>Primary Care Provider: (If not a medical patient of Healthways)</b>	Name:
	Phone Number:

Please indicate your preferred pharmacy: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_