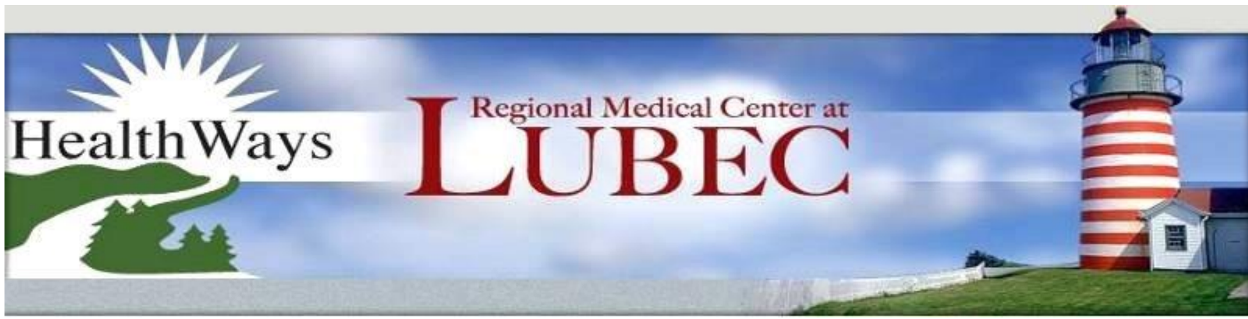


<table>
<tr><th colspan="5">PATIENT DEMOGRAPHIC INFORMATION</th></tr>
<tr><td colspan="3">Patient's Legal Name (First, Middle Initial, Last)</td><td>Social Security Number</td><td>Date of Birth<br>(Month, Day, Year)</td></tr>
<tr><td colspan="2">Preferred First Name:</td><td colspan="2">Maiden Name:</td><td>Gender at Birth:<br>Male ☐<br>Female☐</td></tr>
<tr><td colspan="2">Physical Address:<br><br>Mailing Address:</td><td>City:</td><td>State:</td><td>Zip Code:</td></tr>
<tr><td colspan="2">Marital Status:<br>Married ☐ Single ☐ Divorced ☐<br>Separated ☐ Widowed ☐</td><td colspan="2">Email Address:</td><td>Primary Phone:</td></tr>
<tr><td>Secondary Phone:</td><td colspan="4">Preferred Pharmacy (Name & Town)</td></tr>
<tr><td colspan="5">Does the patient have any problems with: Vision ☐ Hearing ☐ Reading ☐ Speaking ☐ Please Explain for any boxes checked:</td></tr>
</table>

<table>
<tr><th colspan="3">PERSON(S) WHO MAY BE NOTIFIED IN CASES OF EMERGENCY OTHER THAN PARENT/LEGAL GUARDIAN<br>This does not give the individual(s) listed authority to accompany minor to appointment or access medical records.</th></tr>
<tr><td>Name:</td><td>Phone Number:</td><td>Relationship to Patient:</td></tr>
<tr><td>Name:</td><td>Phone Number:</td><td>Relationship to Patient:</td></tr>
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</table>

| MEDICAL INSURANCE INFORMATION<br>**Please provide a copy of ALL insurance cards** | | | |
|---|---|---|---|
| **Primary Medical Insurance** | ☐ Medicare ☐ Medicaid ☐ BCBS/Anthem ☐ Tricare ☐ Other: | | |
| | Insurance Name: | | |
| | Subscriber Name: | Subscriber DOB: | Subscribe Phone Number: |
| | Subscriber Number: | Group Number: | Relationship to Patient: |
| **Secondary Medical Insurance** | Insurance Name: | | |
| | Subscriber Name: | Subscriber DOB: | Subscribe Phone Number: |
| | Subscriber Number: | Group Number: | Relationship to Patient: |
| | | | |

| DENTAL INSURANCE INFORMATION<br>**Please provide a copy of ALL insurance cards** | | | |
|---|---|---|---|
| **Primary Medical Insurance** | ☐ Medicare ☐ Medicaid ☐ BCBS/Anthem ☐ Tricare ☐ Other: | | |
| | Insurance Name: | | |
| | Subscriber Name: | Subscriber DOB: | Subscribe Phone Number: |
| | Subscriber Number: | Group Number: | Relationship to Patient: |
| **Secondary Medical Insurance** | Insurance Name: | | |
| | Subscriber Name: | Subscriber DOB: | Subscribe Phone Number: |
| | Subscriber Number: | Group Number: | Relationship to Patient: |
| | | | |

| **Primary Care Provider: (If not a medical patient of Healthways)** | Name: |
|---|---|
| | Phone Number: |

Please indicate your preferred pharmacy: ______________________________

Signature: ______________________________

Date: ______________________________