Scheduled with: ____ DALE R MYERS MD ____SALLY WHITMAN, PA-C

PATIENT INFORMATION

First Name _____ Last Name _____ Middle Initial _____

Goes by (if different) _____ Age _____ Date of Birth _____ SSN _____

Marital Status: Single_____ Married_____ Divorced_____ Widowed_____ Legally Separated_____

Mailing Address_____ City_____ State_____ Zip_____

Street Address (if different)_____ City_____ State_____ Zip_____

Phone Numbers: Home# _____ Cell# _____ Work# _____

For Appt Reminders call: Home Work Cell Email Address:_____

Employed: N/A_____ Self _____ Fulltime_____ Part time_____ Retired_____

Employer Name_____ Employer Address_____

Spouse / Parent / Legal Guardian Name_____ Phone Number_____

Alternate Emergency Contact_____ Relationship_____ Phone Number_____

Primary Care Physician_____ Phone Number_____

Referring Provider (If applies) _____ Phone Number _____

Pharmacy: Local_____ Mail Order _____

RESPONSIBLE PARTY (if different from patient):

First Name_____ Last Name_____ Relation to patient_____

Address (if different) _____

Date of Birth _____ Phone Number _____

INSURANCE ASSIGNMENT

Complete all blanks

If insurance thru self only need ins name and relation as self

Primary Insurance_____Policy Holder Name_____

Relation to Patient_____ Birth Date_____ SSN_____

Employer Name (if thru work)_____

Secondary Insurance (if applies)_____ Policy Holder Name_____

Relation to Patient_____ Birth Date _____ SSN_____

Employer Name (if thru work)_____

_____ _____

Patient / Legal Guardian Signature Date