Basic Information

| Full Name | | | | |
|-----------------------------------|------------------|------------------------|------|--------|
| First | Middle | Last | | Suffix |
| Sex 🔿 Male 🔿 Female 🔿 Unknown | | Date of Birth | / | / |
| Primary Phone O Home O Mobile O M | Work | Phone Number | | |
| mail | | Social Security Number | | |
| Address Line 1 | | Address Line 2 | | |
| City | | State | Zip | |
| Marital Status | | Maiden Last | | |
| Driver's License State | | Driver's License # | | |
| Demographics | | | | |
| Sexual Orientation | | Gender Identity | | |
| Hispanic or Latino? OYes ONo ODec | cline to Specify | Ethnicity | | |
| Race | | Language | | |
| Emergency Contact | | | | |
| Relationship to Contact | | | | |
| Full Name | | | | |
| | Middle | | Last | |
| Primary Phone O Home O Mobile O M | Work | Phone Number | | |
| Email | | | | |
| Address Line 1 | | Address Line 2 | | |
| City | | State | Zip | |

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Financial Information

| Responsible Party | | | | |
|--|------------------------|------|--|--|
| Who will be financially responsible for you? O Myself O Someone else | | | | |
| If you chose "Someone Else", please fill out the following: | | | | |
| Relationship to Contact | | | | |
| Full Name | | | | |
| First Middle | Last | | | |
| Primary Phone 🔿 Home 🔿 Mobile 🔿 Work | Phone Number | | | |
| Method of Payment | | | | |
| What will be your method of payment? O Insurance O Self-Pa | ау | | | |
| If you chose "Insurance", please fill out the following: | | | | |
| PRIMARY INSURANCE POLICY | | | | |
| Insurance Company | Policy Number | | | |
| Insurance Plan | Insurance Phone Number | | | |
| Group Number | | | | |
| Insurance Company Address | Address Line 2 | | | |
| | | | | |
| City | State | Zip | | |
| Relationship to Primary Policy Holder | | | | |
| If you are not the primary policy holder, please fill out the following: | | | | |
| Full Name | | | | |
| First Middle | | Last | | |
| Sex 🔿 Male 🔿 Female 🔿 Unknown | Date of Birth | | | |
| Policy ID Number | Social Security Number | | | |
| Policy Holder Address | Address Line 2 | | | |
| City | State | Zip | | |
| City | JIALE | μ | | |

If you are unable to provide your insurance information, please provide a reason before continuing.

| SECONDARY INSURANCE POLICY | |
|----------------------------|--|
| | |

If you do not have a secondary insurance policy, you can leave this blank.

| Insurance Company | Policy Number | | | |
|--|------------------------|------|--|--|
| Insurance Plan | Insurance Phone Number | | | |
| Group Number | | | | |
| Insurance Company Address | Address Line 2 | | | |
| City | State | Zip | | |
| Relationship to Secondary Policy Holder | | | | |
| If you are not the secondary policy holder, please fill out the following: | | | | |
| Full Name | | | | |
| First Middle | | Last | | |
| Sex 🔿 Male 🔿 Female 🔿 Unknown | Date of Birth | / / | | |
| Insurance ID Number | Social Security Number | | | |
| Policy Holder Address | Address Line 2 | | | |
| City | State | Zip | | |

Additional Information

Please list your preferred pharmacies in order of preference

| Pharmacy Name | Pharmacy Address |
|---------------|------------------|
| | |
| | |
| | |