**PATIENT INFORMATION PLEASE FILL OUT COMPLETELY**

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| **Patient’s Name:**  **Last First Middle Nickname****Patient Address:** **City: State: Zip:** **Birthdate: Age: Sex:** **RACE: ⁭ White ⁭ Black ⁭ Am Indian/Eskimo/Aleut ⁭ Hispanic ⁭ Asian/Pacific Islander ⁭ Other ⁭ Unknown****ETHNITICITY: ⁭Hispanic or Latino ⁭Not Hispanic or Latino PREFERRED LANGUAGE: ⁭English ⁭Spanish****E-Mail for Lab Results and Statements:**  |

**PARENT INFORMATION**

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| **Father’s Name: Mother’s Name:** **Father’s DOB: Mother’s DOB:** **Social Security Social Security** **Father’s Address Mother’s Address** **Father’s Home Phone Mother’s Home Phone** **Father’s Cell Mother’s Cell** **Employer Employer** **Emergency Contact Name and Phone Number:**  |

**INSURANCE**

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| **Primary Insurance Company: Effective** **Policy Number: Group Number:** **Name of Policy Holder: D.O.B.** **Relationship to patient: ⁭ Father ⁭Mother ⁭ Stepfather ⁭Stepmother ⁭ Other** **Secondary Insurance Company: Effective** **Policy Number: Group Number:** **Name of Policy Holder: D.O.B.** **Relationship to patient: ⁭ Father ⁭Mother ⁭ Stepfather ⁭Stepmother ⁭ Other**  |

**I do hereby authorize the release of any medical information to process the medical claims and request payment of any medical benefits to be made to Vernon A. Mills, M.D., Debra L. Heidgen, M.D., and or Ardeth Tingler-McCann. A.P.R.N.. I understand that any services not covered or paid by my insurance company will be my responsibility. All copays must be paid at time of service.**

**Signed: Date:**