



First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Permanent Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ SS number: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Work Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed  
 Spouse Name: \_\_\_\_\_  
 Spouse Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_  
 Spouse's DOB: \_\_\_\_\_ Spouse's SS number: \_\_\_\_\_

#### EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

I prefer to be contacted by: (Check all that apply)

- Home phone (Message OK  / No message        Work phone (Message OK  / No message   
 Cell phone (Message OK  / No message        Email

#### PHARMACY INFORMATION

My preferred pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Unless initialed this pharmacy will be used for all called in prescriptions \_\_\_\_\_ (initial here)

I prefer to use a mail order prescription service for three months at a time \_\_\_\_\_ (Initial here)

#### INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_ Secondary: \_\_\_\_\_

#### INSURANCE AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claims. I request that all payments be made on my behalf, and that all the benefits be assigned for physician services to Mario Salinas MD or Jennifer McDonald DO. I understand I am responsible for payment of any balance not paid by my insurance company as outlined in my schedule of benefits and as applicable under the law.

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date