Central Medical Clinic Patient Demographic Information

Date: _____

First Name: _____ MI: _____ Last Name: _____

DOB: _____ Race _____ Ethnicity _____ Please Circle: Male/Female

Address: _____ _____ _____ _____
Street City State Zip Code

Preferred Language: _____ Does the patient require an Interpreter: Yes or No

GENERAL INFORMATION

Home Phone: _____ Alt. Phone _____ Ext _____

Email Address _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship: _____

INSURANCE INFORMATION

Private Insurance Provider _____ ID Number _____ Group _____

Subscribers Name (if other than self): _____ DOB _____

Relationship to patient: _____ Subscriber Phone _____

WORK COMP/AUTO INFORMATION

Please Circle, if applicable: Work Comp Auto

Company _____ Claim Number _____ Date of Injury _____

Employer Name, If applicable _____

Attorney Name _____ Phone _____

Adjuster Name _____ Phone _____

PHARMACY INFORMATION

Preferred Pharmacy _____ Phone Number _____

Address: _____ _____ _____ _____
Street City State Zip Code

REMINDER FOR OPIOID PATIENTS- ONLY ONE PHARMACY SHOULD BE USED PER INDIVIDUAL CONTRACT AND AGREEMENT. PHARMACY HOPPING OR THE USE OF A VARIETY OF PHARMACIES IS AGAINST CENTRAL MEDICAL CLINICS CONTROLLED SUBSTANCE AGREEEMENT CONTRACT. IF YOU DO NOT KNOW THE NAME AND LOCATION OF YOUR PREFERRED PHARMACY, IT IS YOUR RESPONSIBILITY TO OBTAIN IT AND INFOR THE CLINIC BEFORE OPIOID PRESCRIPTIONS ARE GIVEN.

To my knowledge, all the given information is correct and current. If the information is incorrect or changes it is my responsibility to notify Central Medical Clinic. I understand that without current and accurate information Central Medical Clinic cannot bill my insurance and I will be responsible for all clinic and medications bills and/or invoices.

Patient Signature: _____ Date: _____