DURST FAMILY MEDICINE

Board Certified Family Physicians // Since 1947

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PLEASE PRINT

Patient Information

Last *First* *Middle* *Nickname* *Maiden Name*

Male ☐ *Female* ☐ *Social Security Number* *Birthdate*

Marital Status ☐ *Married* ☐ *Single* ☐ *Widowed* ☐ *Divorced* ☐ *Separated* ☐ *Other*

Are You A Student? ☐ *Full-time*

Street: Billing Address

City *State* *Zip*

County:

Street: Secondary Address

City *State* *Zip*

County:

Race: *Ethnic Group:*

How did you hear about our practice? ***Emergency Contact Person / Relationship / Phone Number***

( )

Are You A Veteran? ☐ *Yes* ☐ *No* *Smoker?* ☐ *Yes* ☐ *No* ☐ *Part-time*

Cell / Home Phone # ( ) *Day / Work Phone #* ( ) *Preferred Phone #* ( )

Email Address:

Responsible Party Information (if different than above) **(If patient is UNDER 18yrs of age)**

Last *First* *Middle*

Social Security Number *Birthdate* *Sex*

Relationship To Patient:

Primary Insurance Information

Name of Company *Policy #* *Group #*

Name of Insured / SS# / DOB *(if differ from patient info)* *CoPay $* *Deductable $*

Relationship to Patient:

Secondary Insurance Information (if applicable)

Name of Company *Policy #* *Group #*

Name of Insured *Co-Pay Amt: $* Deductable Amt $

Relationship To Patient:

Please provide your preferred pharmacy information. We routinely E-prescribe or fax your prescriptions.

Preferred Pharmacy *Pharmacy Phone Number* ( )

Alternative Pharmacy *Pharmacy Phone Number* ( )

Signature of Patient / Guardian **Date**

X