Patient Information and Consent

What is the reason for your visit? _____

Patient Information				
Name (First, Middle, Last)	Birth Date	Age	Social Security #	Sex ☐ M ☐ F
Address	Apt. #	City	State	Zip
Email Address (iCare will not share your email address-we value your privacy)				
Home Phone	Cell Phone			
Preferred method of contact ☐ Home ☐ Cell OK to leave message? Yes ☐ No ☐				
Employer (or Parent's Occupation if minor)	Work Phone #			
Responsible Party or Parent Name (if minor)	Guarantor Birth Date	Guarantor Social Security #		
Preferred Language	Race ○ American Indian or Alaska Native ○ Asian ○ Black or African American ○ Native Hawaiian or Other Pacific Islander ○ White			
Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino				
How did you hear about us?				

EMERGENCY CONTACT		
Name	Relationship	Home Phone / Cell Phone

Preferred Pharmacy Pharmacy Name	Pharmacy Location

Insurance Please present Insurance Card to Receptionist.	
Primary Insurance Carrier	Secondary Insurance Carrier
Insurance Company Name	Insurance Company Name
Policy #	Policy #
Group #/Name	Group #/Name
Insured Name & DOB	Insured Name & DOB
Patient's relationship to insured (Circle One) Self Spouse Dependent	Patient's relationship to insured (Circle One) Self Spouse Dependent