Patient Information

Date	**Preferred Pharmacy: Name & Location**		
Name: Last	**First**	**Middle (initial)**	
Date of Birth:	**Sex** Male Female	**Social Security Number**	
Marital Status Single Married Divorced Widowed Other		**Drivers License Number**	
Billing Address			
Zip	**City**	**State**	
Phone: Home	**Work**	**Cell**	**Preferred Contact Number** Home Work Cell
Preferred Communication	**Email Address**		
Emergency Contact: Name, Address and Phone Number of nearest friend of relative *not* living with you.		**Relationship**	
Patient Employer Name	**Occupation**	**Contact Number**	
Spouse Employer Name	**Occupation**	**Contact Number**	

Insurance Coverage – *Primary Plan*	**Insurance Coverage – *Secondary Plan (if applicable)***
Insured Name **Policy Holder Name, DOB, Relationship**	**Insured Name** **Policy Holder Name, DOB, Relationship**
Policy Number **Group Number**	**Policy Number** **Group Number**
Effective Date	**Effective Date**

Release of PHI

As outlined in Monarch Healthcare's "Notice of Privacy Practices", we may disclose your protected health information (PHI) to individuals or entities involved in your healthcare. Provide the names of individuals you ***do not*** want to receive your PHI.

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Release for Treatment of a Minor

Except under certain legal exemptions, a parent or guardian signature is required for the treatment of a minor. I am the parent/guardian for

_____
Name of Minor

and give Monarch Healthcare authorization to provide treatment.

_____
Parent/Guardian Signature

_____
Witness Date

Consent for Treatment

I consent to examination, diagnosis and medical care including office lab services (blood draws), injections and imaging (ultrasound, AFI) to be performed by providers and employees of Monarch Healthcare.

_____
Patient or Guardian Signature

_____
Date