Patient Information

Date	Preferred Pharmacy: Name & Location	
Last Name	First Name	Middle (initial)
Date of Birth	Sex Male Female	Social Security Number
Marital Status Single Married Divorced Widowed Other		Driver's License Number
Billing Address		
Zip	City	State

Phone: Home	Work	Cell	Preferred Contact Number Home Work Cell
Who should we thank for referring you?		Email Address	
Emergency Contact: Name of nearest friend or relative		Phone number	Relationship

Patient Employer Name	Occupation	Contact Number
Spouse Name DOB & Employer Name	Occupation	Contact Number

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

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.

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Parent/Guardian Signature

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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.

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Patient or Guardian Signature

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Date