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.

_____

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