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				Today's Date:	
Patient's Name		Birthdate	Age	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Marital Status Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/>
IF PATIENT IS A MINOR (UNDER 18), PARENT'S NAME OR GUARDIAN'S NAME:					
Relationship to patient:		Last Name:		First Name:	
Residence Address:				Apartment Number	
City			Zip Code		
Home Telephone: ()			Employer		
Business Telephone: () EXT#			Business Address		
Cellular Telephone: ()				Social Security number	
Name of Referring Doctor:				Name of Pharmacy:	
Referring Doctor phone number: ()				Pharmacy tel. Number	
How were you referred to our practice? <input type="checkbox"/> Self <input type="checkbox"/> Insurance <input type="checkbox"/> Other _____				()	
<input type="checkbox"/> Physician <input type="checkbox"/> Hospital <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Internet <input type="checkbox"/> Friend/ Family or Current patient				Your E-Mail Address	
PRIMARY INSURANCE INFORMATION			SECONDARY INSURANCE INFORMATION		
Do you have Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have TEXAN PLUS (Medicare HMO)? <input type="checkbox"/> YES <input type="checkbox"/> NO			NAME OF INSURANCE:		
NAME OF INSURANCE:			NAME OF INSURED:		Birthdate
NAME OF INSURED:		Birthdate			
Social Security No.		Relationship to patient: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other:			
Employer:		Bus. Telephone No.		Employer:	
				Business Tel. No.	
Business Address:			Business Address:		
INSURANCE ID #			INSURANCE ID #		
INSURANCE GROUP/PLAN #			INSURANCE GROUP/PLAN #		
INSURANCE TEL: ()			INSURANCE TEL: ()		
EMERGENCY CONTACT INFORMATION					
Name:		Relationship:		Emergency Contact Tel. No. ()	
Reason for appointment/Chief Complaint:					