Section I: Patient Information
Patient Name (first, mi, last):
Gender: ☐ Male ☐ Female
Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐Transgender Female ☐GenderQueer
Sexual Orientation: ☐ Straight ☐ Gay ☐Lesbian ☐Bisexual ☐Other ☐ Decline
Birth Date(MM/DD/YY):
Marital Status: ☐ Single ☐Married ☐Divorced ☐ Widowed ☐Legally Separated ☐Unknown
Race: (if your Ethnicity is Hispanic/Latino, please select White or Black) ☐White/Caucasian ☐ SubContinent AsianAmerican ☐Black/African American ☐American Indian or Alaskan Native ☐Asian ☐Native Hawaiian ☐Native American ☐Other Race ☐Asian Pacific American ☐More Than One Race ☐Pacific Islander
Ethnicity: ☐Hispanic/Latino ☐Other
Language: ☐ English ☐Spanish ☐Other_____
Employment: ☐ Employed ☐ Self-Employed ☐ Unemployed ☐Disabled ☐Retired ☐Part-time Student ☐Full-time Student
Employer Name:
Employer Address:
Employer Phone:
Patient Mailing Address:
City: **State:** **Zip Code:**
Home Phone: **Cell Phone:** **Work Phone:**
Email address:
Preferred Provider:
How did you hear about us? __ CommWell Website __ Facebook __ Twitter __ Newspaper __ Family __ Friend __ Flyer/Brochure __ Radio __ Billboard __ Magazine __ Other_____
Section II: Person Responsible for Bill (if different than above):
Name (first, mi, last):
Patient's Relation to Guarantor:
Gender: ☐ Male ☐ Female
Birth Date(MM/DD/YY):
Marital Status: ☐ Single ☐Married ☐Divorced ☐ Widowed ☐Legally Separated ☐Unknown
Language: ☐ English ☐Spanish ☐Other_____
Employment: ☐ Employed ☐ Self-Employed ☐ Unemployed ☐Disabled ☐Retired ☐Part-time Student ☐Full-time Student
Employer Name:
Employer Address:
Employer Phone:
Guarantor's Mailing Address:
City: State: Zip Code:
Home Phone: Cell Phone: Work Phone:

Section III: Insurance Information:		
Type: ☐Medicaid ☐Medicare ☐Private Insurance ☐No Insurance		
Ins. Co. Name:		
Claim Member ID# :		
Group # :		
Effective Date:		
Policy Holder Name:		
Relationship to Patient:		
Occupation:		
Section III cont: Secondary Insurance Information:		
Type: ☐Medicaid ☐Medicare ☐Private Insurance ☐No Insurance		
Ins. Co. Name:		
Claim Member ID# :		
Group # :		
Effective Date:		
Policy Holder Name:		
Relationship to Patient:		
Occupation:		
Section IV: Emergency Contacts		
Name (first, mi, last):		
Home Phone:	Cell Phone:	Work Phone:
Relationship to Patient:		
Name (first, mi, last):		
Home Phone:	Cell Phone:	Work Phone:
Relationship to Patient:		
Section V: Pharmacy		
Name of Pharmacy:		
Location of Pharmacy:		