

Enlightened Primary Care

Patient Information / EMR #

Patient Name: _____ **DOB:** ____/____/____

Social Security Number: _____ **(Required)**

***If Minor (under age 18) Responsible Adult(s):** _____

Best Contact Number: () _____ **Who's phone is this?**

Alternate / Emergency: () _____ **Who's phone is this?**

E-mail Address (Print Clearly): _____

Primary Address: _____

Address (continued): _____

Preferred Pharmacy: HEB/ Walmart/ CVS/ Walgreen's/ Costco/

Sam's/ Target/ Other: _____ **Phone #** _____

Medical Insurance (Check Applicable)

_____ None (Private Pay)

_____ Medicare / Supplement (Y / N) : Traditional PPO / Managed Care (HMO)

_____ Commercial Insurance: (HMO / PPO / other: _____

Policy Owner Name: _____ **DOB:** ____/____/____

Primary Care Provider: _____

Office # () _____ **/ Fax #** () _____ **(Fax is Important)**

Referring Physician / PA / NP: _____

Office # () _____ **/ Fax #** () _____ **(Fax is Important)**