Patient Demographics

General Information

Date:	Personal Email:		
Name:		Cell Phone:	
Address:		Home Phone:	
City:	State:	Zip:	
Date of Birth:		Last 4 of SSN:	
Birth Sex ☐ Male ☐ Female ☐ Neither		Gender Identity ☐ Male ☐ Female ☐ Transgender ☐ Genderqueer ☐ Other______________ ☐ Choose not to disclose	
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify		Language ☐ English ☐ Spanish ☐ Other_________	
Race ☐ Asian ☐ White	☐ Black or African American ☐ American Indian/Alaskan Native	☐ Native Hawaiian/Pacific Islander ☐ Decline to Specify	☐ Other____________

General Information

Covered Employee:	Department:
Work Phone:	Cell Phone:

Insurance Information

☐ Employee ☐ Spouse ☐ Dependent	Last 4 of Employee SSN:
Insurance Name:	
ID#:	Group:

Emergency Contact

Name:	
Relationship:	Phone:

Pharmacy Information

Preferred Pharmacy:		
Location:	Phone:	
City:	State:	Zip:

I voluntarily give permission to the health care providers and assistants of CareATC to provide medical services as they deem necessary. I understand that by signing this form I am authorizing CareATC to treat me the entirety of the time that I seek services from the company.

____

Patient Signature (or Representative if Minor) Date

____

Relationship to Patient