Patient Demographics

General Information

Date:	Personal Email:	
Name:		Cell Phone:
Address:		Home Phone:
City:	State:	Zip:
Date of Birth:	Gender: ☐ Male ☐ Female	SSN:
Race:	Language: ☐ English ☐ Spanish ☐ Other:	

Covered Employee Information

Covered Employee:	Department:
Work Phone:	Cell Phone:

Insurance Information

☐ Employee ☐ Spouse ☐ Dependent	Employee SSN:
Insurance Name:	Insurance Phone:
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