



Section I: Patient Information		
Patient Name (first, mi, last):		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> GenderQueer		
Sexual Orientation: <input type="checkbox"/> Straight <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Other <input type="checkbox"/> Decline		
Birth Date(MM/DD/YY):		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Unknown		
Race: (if your Ethnicity is Hispanic/Latino, please select White or Black)		
<input type="checkbox"/> White/Caucasian <input type="checkbox"/> SubContinent AsianAmerican <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Native American <input type="checkbox"/> Other Race <input type="checkbox"/> Asian Pacific American <input type="checkbox"/> More Than One Race <input type="checkbox"/> Pacific Islander		
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other		
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____		
Employment: <input type="checkbox"/> Employed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Part-time Student <input type="checkbox"/> 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: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Birth Date(MM/DD/YY):		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Unknown		
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____		
Employment: <input type="checkbox"/> Employed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Part-time Student <input type="checkbox"/> 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: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Insurance <input type="checkbox"/> 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: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Insurance <input type="checkbox"/> 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:		