MDVIP-AI 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)

Insurance name: _____

Commercial Insurance: (____ HMO/ ____PPO / other: _____

Medicare / Supplement (____Y /____N)/ ____ Traditional PPO / ____Managed Care (HMO)

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

Primary Care Provider: _____Office # ( )_____

Fax # ( ) _____(Fax is Important)

Referring Physician / PA / NP: _____Office # ( ) _____

Fax # ( ) _____(Fax is Important)