First Name	**MI**	**Last Name**	**Suffix**
Patient goes by		**Prefix Mr Mrs Ms Dr Other_____**	
Date of Birth		**Male / Female**	**Marital Status**
Address			
City	**State**	**Zip Code**	
Home #	**Work #**	**Cell #**	
Preferred Phone H W C	**Is it okay to leave a detailed message? Y / N**		
Email Address			
Emergency Contact		**Relationship**	
Emergency Contact Phone Number			
Employer		**Occupation**	

Name of Person Financially Responsible		
Address (if different from above)		
City	**State**	**Zip Code**
Home #	**Work #**	**Cell #**
Relationship to Patient (Child, Spouse, Self)		

Primary Medical Doctor
Referring Doctor
Name & Location of Local Pharmacy
Name of Prescription Mail-In Service

1. PRIMARY INSURANCE: **Insurance Company Name**	
Policy Holders Name	
Date of Birth	**Relationship to Patient**
2. SECONDARY INSURANCE: **Insurance Company Name**	
Policy Holders Name	
Date of Birth	**Relationship to Patient**
3. TERTIARY INSURANCE: **Insurance Company Name**	
Policy Holders Name	
Date of Birth	**Relationship to Patient**

I certify that the information I entered is accurate and true to the best of my knowledge and is only to be used for treatment, billing and processing of insurance benefits. I will not hold *Alan R Malouf MD PA* responsible for any errors or omissions that I have made in the completion of this form. I further authorize any release of necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled. This authorization may be revoked by me at any time in writing. I authorize *Alan R Malouf MD PA* to release and or send medical information regarding my case to other consulting and/or referring physicians.

I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered.

PATIENT/GUARDIAN SIGNATURE: _____ ***DATE:*** _____