Patient Information			
Name			DOB *(MM/DD/YYYY):*
Gender: ☐ Male ☐ Female ☐ Other: _____		Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____	
Address:			City
State:	Zip:	Phone:	
Email:		Preferred Contact Method: ☐ Phone ☐ Email ☐Text	
Primary language:			Interpreter needed? ☐ Yes ☐ No
Emergency Contact Name:			Phone:
Relationship to Patient			
Insurance Information *(if applicable)*			
Provider:		Policy number:	
Group Number:		Policyholder Name	
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____			
Pharmacy Information			
Preferred Pharmacy Name:		Phone Number:	
Address:			
Consent & Signature			
I confirm that the information provided is accurate to the best of my knowledge.			
Signature:			Date: