Patient Information Form

Gold ☐ Silver ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐ I II III

First Name	Last Name		MI
Address	City, State		Zip
Social Security-**last 4 only**	Birth Date	Sex	Marital Status
Home Phone	Cell Phone		E-Mail
Employer's Name			Work Phone
Employer's Address			Occupation
Local Pharmacy Name, Address & Phone: Mail Order Pharmacy Name, Address & Phone:			
Emergency Contact Name, Relationship & Phone			
Do we have your permission to leave medical information on your home and/or cell voice mail? Please circle: ☐ Yes / ☐ No Do we have your permission to e-mail you with medical information and/or information related to the office? Please circle: ☐ Yes/ ☐ No Who may we speak to in regards to your medical care? _____			Contact Preference
If applicable:			
Spouse's Name & Birth Date			
Spouse's Employer, Work Phone & Occupation			

Please provide Your Private MD, LLC with a **copy of your insurance cards (front and back)**. The insurance information is strictly for the coordination of care. Your Private MD, LLC will not bill your insurance nor Medicare for any services provided by Your Private MD, LLC.

I authorize Your Private MD, LLC to furnish professional services to me or my dependent as are necessary in the prevention, diagnosis, or treatment of any illness or injury.

Signed: _____ **Date:** _____

Type Patient Name: _____

Referred by: _____