

Today's Date _____

Patient Information

 Name _____ Date of Birth _____ Age _____
Last name First name MI
 Address _____
Street Apt # City State Zip
 Mailing Address _____
If different than above City State Zip
 Home Phone () _____ Email _____
 Cell Phone () _____ Sex: M F Status: S M D W

Additional Information for PATIENT or Guardian (Required)

 Name of responsible person if other than patient or if patient is a minor _____
 Relationship to Patient _____ Social Security # _____
 Home Phone () _____ Cell Phone () _____
 E-Mail _____ Date of Birth _____

Emergency Contact Information

 Name of Person to Contact _____
 Phone () _____ Relationship to Patient _____

_____ Initial here to authorize CEI Medical Group to disclose your private health information to this individual and/or leave voice mail messages regarding your private health information

Insurance Information
Primary Insurance
Secondary Insurance

 Insurance Co. Name _____
 Subscriber Name _____
 Subscriber I.D. # _____
 Group or Policy # _____
 Subscriber Date of Birth _____
 Relationship to Patient _____

 Insurance Co. Name _____
 Subscriber Name _____
 Subscriber I.D. # _____
 Group or Policy # _____
 Subscriber Date of Birth _____
 Relationship to Patient _____

How Did You Hear About Us?

 Referred By _____ Specialty _____
 Address _____ Phone () _____

 Or Yellow Pages Relative Friend Employee Event Other _____

 Who is your Primary Care Physician? _____
 Address _____ Phone () _____

Other

 I would like to receive newsletters and/or information about CEI Medical Group events Yes No
 CEI Medical Group may leave voice mail messages containing my private health Yes No
 Information on any of the phone numbers listed on this form.

Patient Signature _____ **Date** _____

Office Visits – Initial next to the date of your office visit if none of the above information has changed since your last visit.

OV _____ Initial _____ OV _____ Initial _____ OV _____ Initial _____

OV _____ Initial _____ OV _____ Initial _____ OV _____ Initial _____