Theresa Lerch CFNP CNM Lori Bowdler FNP-BC Caitlin Shea FNP-C

PLEASE COMPLETE ENTIRE FORM Today's date _____ Male_____Female_____
please list your name as it reads on your insurance card

Name(First)_____(Middle)_____(Last)_____

Social Security#_____Date of Birth_____Place of Birth _____

For privacy purposes, please only indicate numbers that we are allowed to use to communicate results, appointments, etc:

Home Phone #_____Work Phone#_____Cell#_____

Mailing Address_____City_____State_____Zip code_____
□ Same
Physical Address_____City_____State_____Zip code_____

Race (please indicate per federal guideline requirements)
□ American Indian
□ Asian
□ Black or African American
□ Hispanic
□ Indian
□ Middle Eastern
□ Native Hawaiian or other Pacific Islander
□ White
□ decline to specify

Ethnicity (please indicate)
□ Hispanic or Latino
□ Not Hispanic or Latino
□ decline to specify

Please check here ☐ if the front desk verified your insurance information

Primary Insurance Company _____
Guarantor's Name _____Insurance ID# _____
Group# _____ Guarantor's Date of Birth/Relationship to patient_____/_____
Where do you want billing statements sent? □ Patient Address (listed above) □ Guarantor (list info below)
Guarantor mailing address _____
Guarantor's phone number in case of insurance related questions _____

Employer or School Info_____Occupation_____

Spouse's Name (if applicable)_____ Spouse Date of Birth_____

For Pediatric Patients: Dad's Name_____Mom's Name_____

→ VERIFY YOUR CURRENT PHARMACY _____City_____

Your email address_____
I give permission to contact me re: appointments, billing and results via email □ yes □ no

□ I am an established patient
□ I am a new patient → how did you hear about us?_____

Emergency Contact Information: (other than spouse)

Name_____**Relationship** _____

Home Phone # _____**Work Phone #**_____ **Cell Phone #**_____

Signature_____**Date** _____

This form is to be updated annually