UNIVERSAL MEDICINE

Comprehensive Personalized Medical Care

Last Name:	First Name:		MI:
Home Phone:	Work:	Cell:	
Address:			
City:	State:	Zip Code:	
Date of Birth:	Age:	Sex: M / F	Marital Status:
Social Security #:	Email Address:		
Medical Doctor:	Referring Doctor:		
Pharmacy Name:			
Pharmacy Town & Phone (if applicable):			
Patient's Employer:			
Employer's Address:			
In case of emergency, notify:			
Phone Number:	Relationship:		

Primary Insurance Company	Secondary Insurance Company
Name:	Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone Number:	Phone Number:
ID#:	ID#:
Group#:	Group#:

Subscriber Information	Subscriber Information
Name:	Name:
SSN:	SSN:
DOB:	DOB:
Employer:	Employer:

Race: (check one)

[ ] African American [ ] American Indian or Alaska Native
[ ] Asian [ ] Caucasian
[ ] Native Hawaiian [ ] Other Pacific Islander
[ ] More than one [ ] Prefer not to say

Ethnicity: (check one)

[ ] Hispanic or Latino
[ ] Neither Hispanic nor Latino

Preferred Notification Method: (check one)

[ ] Mail [ ] Phone [ ] Email

Check off to authorize our staff to leave a message: (test results, appointment reminders)

[ ] On your voice mail
[ ] With a family member
[ ] Speak to me directly

Signature: Date: