Patient Information:

Last Name:	First Name:	Middle Initial:
Birthdate: / /	Gender:	Social Security#:
Marital Status: □ Single□ □ Married□ □ Divorced □□ Widowed□		
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Mailing Address:	Zip: City:	State:
Primary Language:	Race:	Ethnicity:
Preferred Pharmacy:	City:	
Email:		

If Patient Is A Minor Please Complete:

Name of Parent/Guardian:		Guarantor Date of Birth:
Mailing Address:	Zip:	
City:	State:	Phone:
Social Security#:	Relationship to Patient:	

Primary Insurance Information:

Name of Insured:	Date of Birth:	Social Security #:
Relationship to Insured:	Insurance Address:	
Zip:	City:	State:
Insurance Carrier Name:	Policy/Group#:	

Student Information:

Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate ☐

Person to Notify in Case of Emergency:

Name (Not in Same Household):		
Street Address:	Zip:	City:
Home Phone:	Relation to Patient:	

Employer Information (If Patient Is A Minor, Parent/Guardian, Please Complete):

Employer Name:		Occupation:	
Street Address:			
Zip:	City:	State:	Employer's Phone:

Please describe your illness/injury/symptoms and date of onset: _____

We request payment at time of service. We are contracted with some insurance carriers and may be able to bill directly for you. Please provide us with a copy of your insurance card. If co-payment/deductible is part of your plan, we request that your portion is paid at the time of service. I hereby authorize the release of medical information to insurance carriers needed to process a claim and request payment either to myself or to Doctors on Duty, for medical service rendered. **I understand that I am financially responsible for all charges whether or not covered by insurance, and that I will be expected to pay if insurance has not paid within 60 days. Doctors on Duty may add a monthly rebilling fee for overdue balances. I hereby consent to treatment at Doctors on Duty Medical Clinics.**

Signature:_____ Relationship: _____ Date: _____