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| Today’s Date: How did you hear about our practice?Dr. Kershisnik / Dr. Ritchie / Suboxone |

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| Patients Name: |
| Previous Names / Maiden Name / Aliases: |
| Nickname (what do you want us to call you?): |
| Home Address: City: State: Zip: |
| Mailing Address (if different from home): |
| Email Address: | Employer: |
| Home Phone: ( ) | Work: ( ) | Cell: ( ) |
| Date of Birth: | Sex (please circle): Female Male | Pharmacy: |
| Race/Ethnicity (please circle one): Caucasian African American Asian Hispanic Native American Native Alaskan Pacific Islander Other |

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| **If the patient is under 18 please complete this section:** |
| **Father’s Information** |
| Father’s Name: |
| Phone Number (if different from above): Home ( ) Cell ( ) Work ( )  |
| Address (if different from above): |
| **Mother’s Information** |
| Mother’s Name: |
| Phone Number (if different from above): Home ( ) Cell ( ) Work ( )  |
| Address of Mother (if different from above) |

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| **Insurance information + Copy of cards (Vantage Physicians does not bill insurance for any services rendered, but we need this information to assist with coordination of referrals, etc.. when applicable)** |
| **Insurance Carrier’s** **Information** |
| Company Name: |
| Address: |
| Phone: ( ) | Fax: ( ) | E-Mail:  |
| **Main Subscriber’s Information** |
| Name: | Employer: |
| Date of Birth: | Sex (please circle): Female Male |
| Address (if different from patient): |
| Main Subscribers Phone Number (if different from patient):Home ( ) Cell ( ) Work ( )  |
| **Patient’s Information** |
| Insurance ID #: | Insurance Group #: |

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| **Emergency Contact Information:** |
| Name: | Name: |
| Relationship: | Relationship: |
| Home Phone: | Home Phone: |
| Work Phone: | Work Phone: |
| Cell: | Cell: |
| Address: | Address: |