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

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| Patients Name: Nickname: | | | | | |
| Previous Names / Maiden Name / Aliases: | | | | | |
| Home Address:  City: State: Zip: | | | | | |
| Mailing Address (if different from home): | | | | | |
| Home Phone: | | Work Phone: | | | Cell Phone: |
| Email Address: | | | Employer: | | |
| How would you like to receive appointment reminders? text message / email / voice message | | | | | |
| 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: |