



Date

PATIENT INFORMATION

Patient Name (Last, First, MI), Social Security Number, Birth Date, Sex, Marital Status, Home Address, State, Zip Code, Home Phone, Work Phone, Alternate Number, Cell Phone, E-Mail Address, Would You Like to Receive Information by E-Mail?, Employer Name and Address, Are you currently taking 5 or more medications?, How did you hear about SMG?, Whom should we thank for your referral?

GUARANTOR INFORMATION

(PERSON FINANCIALLY RESPONSIBLE FOR BILLS AFTER INSURANCE COMPANY PAYMENT)

Please Check Box to Indicate if Information is Same as Patient, Guarantor Name, Social Security Number, Patient's Relationship to Guarantor, Home Address, State, Zip Code, Home Phone, Work Phone, Employer Name and Address

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE COMPANY

Insurance ID No. (Member/Certificate), Plan Name, Plan No., Group No., Subscriber Name, Effective Date, Social Security Number, Subscriber D.O.B., Primary Care Physician, Patient's Relationship to Subscriber

SECONDARY MEDICAL INSURANCE COMPANY

Insurance ID No. (Member/Certificate), Plan Name, Plan No., Group No., Subscriber Name, Effective Date, Social Security Number, Subscriber D.O.B., Patient's Relationship to Subscriber

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name, Phone Number