Part I

Instructions

A response to any question or section is optional. If you do not wish to disclose specific information, simply leave the section blank. This form is designed to be machine readable. USE ALL CAPITAL LETTERS, one letter per space. Example: A B C

Fill all bubbles completely. Example: ● Incorrectexamples ⊗ ◐

Use only BLACK INK.

Please fill out all dates as Month / Day / Year. For example, December 20, 2009 would be 1 2 / 2 0 / 2 0 0 9

Use four digit years where indicated.

Primary Cardholder Information

Cardholder ID# Social Security

First Name Middle Initial

Last Name Suffix

Steet Number Street Name Apt.#

City State Country Zip -

Daytime Telephone ( ) - Evening Telephone ( ) -

E-mail

Physical Profile

Height Inches Weight lbs Sex ○ Male ○ Female Date of Birth / /

Marital Status ○ Single ○ Married ○ Divorced ○ Widow/Widower Number of Minor Children

Race ○ White/Caucasian ○ Black/African descent ○ Middle Eastern ○ Asian ○ Other/Not Listed ○ Native American ○ Latino/Hispanic ○ East Indian ○ Islander

Hair Color ○ Auburn/Red ○ Black ○ Blonde ○ Salt and Pepper Gray ○ Bald ○ Dark Brown ○ Light Brown ○ Dark Blonde ○ White or Gray ○ Other/Not Listed

Eye Color ○ Black ○ Blue ○ Brown ○ Gray ○ Green ○ Hazel ○ Other/Not Listed

Next of Kin Emergency Contact

First

Full Name:

Daytime Phone: ( ) - Evening Telephone ( ) -

Relationship ○ Spouse ○ Child ○ Parent ○ Brother/Sister ○ Guardian ○ Other:

Second

Full Name:

Daytime Phone: ( ) - Evening Telephone ( ) -

Relationship ○ Spouse ○ Child ○ Parent ○ Brother/Sister ○ Guardian ○ Other:

Primary Insurance

Insurance Company Name

Policy Holders Name

Group#

Policy ID#

Phone# ( ) -

Secondary Insurance

Insurance Company

Policy Holders Name

Group#

Policy ID#

Phone# ( ) -

In signature and in disclosure, the bearer of the electronic medical record keeping system, as a smart card program of emergency medical and administrative access, assures payment in full by the patient/cardholder and their medical insurance benefits carrier to the medical treatment facility executing any and all medical procedures granted to the patient/cardholder.

Primary Care Physician Practice Name

Phone# ( ) -

See PART III - Physician's Signature