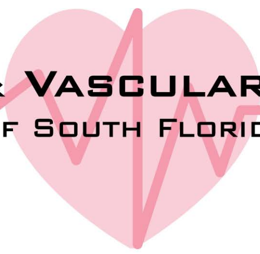


Patient Information Form v2024

**Dr. Luis Tami**

- New Patient
- Existing Patient

# Patient Information

Name:_______________________________________________DOB:____________

Address:________________________________________________ Apt:_________

State:___________ City:___________________________ Zip:________________

Phone#___________________________ Cell#______________________________

Email:_________________________________________________________________

Emergency Contact Name:______________________________________________

Phone#______________________________ Cell#___________________________

Relation:_______________________________________________________________

# Primary Care Doctor (PCP), Insurance & Pharmacy Information

Doctor Name:_________________________________________________________

Phone #__________________________ Date of Last Visit:__________________

Address:________________________________________________________________

Insurance Provider:___________________________________________________

Subscriber#_________________________ Group#__________________________

Phone# (back of insurance card):________________________________________

Pharmacy Name (be specific):__________________________________________

_______________________________________________________________________

Phone #______________________________ City:__________________________