Oklahoma Medical Research Foundation
Clinical Pharmacology
825 Northeast 13th Street
Oklahoma City, OK 73104

PATIENT INFORMATION

(Please use legal name)
PLEASE PRINT CLEARLY

Name of Patient _____ Birth Date_____/_____/_____
(Last) (First) (MI)
Age: ____ Gender: Male Female Social Security #: _____/_____/_____ Race_____ Ethnicity _____

Home Address: _____
(Street) (City) (State) (Zip)
Mailing Address: _____
(Street) (City) (State) (Zip)
Cell Phone #: _____ Home Phone #: _____

E-mail address:_____ Language:_____ Interpreter Needed?_____

Employer: _____ Work Phone#:_____ Ext. _____

Emergency Contact: _____ Home Phone # (____)_____
(Name) (Emergency Contact)
Relationship to Patient: _____ Cell Phone # (____)_____
(Emergency Contact)
Referring Physician: _____ Phone #: _____

Primary Care Physician:_____ Effective Date:_____

Address: _____City: _____

State: _____ Zip:_____Phone #: (___) _____

Insurance Information: ***We will need a copy of the insurance card in order to file a claim.***
Primary Insurance Coverage: _____Policy #: _____
Group #: _____Insured Name: _____
Male Female DOB: _____ SSN#:_____
Relationship to Patient:_____ Primary Insured Employer: _____

Secondary Insurance Coverage: _____ Policy #: _____
Group #: _____Insured Name: _____
Male Female DOB: _____ SSN#:_____
Relationship to Patient:_____ Primary Insured Employer: _____

Guarantor Name:_____ Address:_____

City:_____State:_____Zip:_____Phone:(___)_____

Marital Status:_____ Spouse Name:_____ Contact Number_____

Pharmacy Name:_____Phone:_____Fax:_____

Patient/Signature:
I hereby apply for treatment by the physicians of this practice and or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled to this practice. I understand that payment is due at the time of service and that I am financially responsible for all charges, whether or not paid by insurance.

Signature: _____ **Date:** _____/_____/_____