Paresh N. Varu, MD

**Patient's Name**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Today's Date:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Age**: **\_\_\_\_\_\_\_**

**Address**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Sex:**  ❏ Male ❏ Female

**City:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **State\_\_\_\_\_\_\_** **Zip**: **\_\_\_\_\_\_\_\_\_**

**Social Security #:** **\_\_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_\_\_** **Driver’s License#:** \_\_\_\_\_\_\_\_\_\_\_\_

**Phone #:** Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Method of Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone#**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referred by:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Present Work**

**Status:** ❏ Employed ❏ Unemployed ❏ Retired ❏ Disabled

**Marital Status:** ❏ Single ❏ Married ❏ Divorced ❏ Domestic Partner ❏ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Primary Care Physician:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Physicians involved in your care:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred** **Pharmacy:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Info:**

**Primary Insurance Company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ID#:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group#:** \_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ID#:**  \_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group#:** \_\_\_\_\_\_\_\_\_\_\_