



Employer's Address: _____
Street City State Zip Code

Referred by: ☐ Physician ☐ Friend ☐ Other:

EMERGENCY CONTACT:

I authorize personnel of Southland Integrated Services, Inc. to release all medical information to my emergency contact listed below.

Name _____ Relationship _____ Phone number _____

PHARMACY LOCATION:

[Name] [Street] [City] [Zip code]

PRIMARY INSURANCE:

Company Name: _____ Group/Plan #: _____ Member #: _____

Name of Policy Holder/Responsible Party: _____

SELF-CERTIFICATION AFFIDAVIT:

Number of family members (Spouse + Dependents under 18 years old): _____

Monthly family gross income: \$ _____

☐ By checking this box, I certify that the information given is true, correct and complete to the best of my knowledge, any changes will be reported immediately.

Signature of Patient/Parents or Guardian (If minor)

Date

OFFICE USE ONLY:

Self-determination: ☐ A ☐ B ☐ C ☐ D ☐ E

Completed by: _____



“A NON-PROFIT ORGANIZATION SINCE 1979”

9862 Chapman Ave. Garden Grove, CA 92841

www.southlandintegrated.org | info@southlandintegrated.org