

Today's Date _____

PATIENT INFORMATION

Last Name _____

First Name _____

Middle Initial _____

Birth Date _____

Age _____

Gender _____

Marital Status:

- Married Never Married
- Widowed Divorced Annulled
- Domestic Partner
- Legally Separated

Social Security # _____

CONTACT INFORMATION

Address Line 1 _____

City/State/Zip Code _____

Home Phone _____

Work Phone _____

Cell Phone _____

Email _____

Contact Preference: Select your choice

Primary Address Home Phone Work Phone Cell Phone Email

Permission To Send Appointment Reminder by Email? Yes No

Employer _____

Employer Address/Phone# _____

Occupation _____

ETHNICITY/RACE/LANGUAGE

Ethnicity: Select your choice.

- Not Hispanic Not Latino
- Hispanic Latino
- Ethnicity Not Known
- Ethnicity Disclosure Declined

Race: Select up to 3 Entries.

- American Indian Alaska Native
- Asian Black or African American
- Native Hawaiian
- Other Pacific Islander White
- Other Race Race Not known
- Race Disclosure Declined

Primary Language _____

Additional Languages _____

Are you being referred by another physician? Yes No

Reason For Visit _____

Referring Physician _____

Primary Care Physician _____

Consent Given to Share Clinical Information? Yes No

OTHER CONTACT: Select your choice: Agent Caregiver Emergency Contact
Guardian Next of Kin Personal

Name & Relation To Patient _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

OTHER CONTACT: Select your choice: Agent Caregiver Emergency Contact
Guardian Next of Kin Personal

Name & Relation To Patient _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

PATIENT INSURANCE INFORMATION:

Date: _____

Last Name: _____ First Name: _____ MI: _____

Primary Insurance

Insurance Company Name: _____

Insurance Company Address: _____

Relation to Insured: Self, Child, Spouse, Other Insurance ID# _____

Insured is a Company: Yes, No Group Number _____

Insured's Last Name: _____ First Name: _____ MI: _____

Sex: Male, Female Insured's Date of Birth: ____ - ____ - ____

Address: _____ City: _____

State: _____ Zip: _____

Phone: ____ - ____ - ____ Employer's Name: _____

Co-Pay Amount: Primary _____, Specialist _____.

Secondary Insurance

Insurance Company Name: _____

Insurance Company Address: _____

Relation to Insured: Self, Child, Spouse, Other Insurance ID# _____

Insured is a Company: Yes, No Group Number _____

Insured's Last Name: _____ First Name: _____ MI: _____

Sex: Male, Female Insured's Date of Birth: ____ - ____ - ____

Address: _____ City: _____

State: _____ Zip: _____

Phone: ____ - ____ - ____ Employer's Name: _____

Co-Pay Amount: Primary _____, Specialist _____.