PATIENT INFORMATION

Thank you for choosing our office!!! In order to serve you properly, we need the following information. Please **Print Clearly**. All information will be confidential.

Name: _____ Date: ____/____/____

D.O.B.:____/____/____ Age: _____ Sex: ___ M ___ F Marital Status: ___S ___M ___D ___W

Address: _____Apt #: _____City: _____ Zip: _____

SSN: _____ E-mail: _____

Home Ph: (___) _____Work Ph: (____) _____Cell.Ph: (____) _____

ETHNICITY:
- ☐Hispanic or Latino
- ☐Not Hispanic or Latino
- ☐Unknown or decline

PREFERRED LANGUAGE:
- ☐English
- ☐Spanish
- ☐Other

RACE: ☐White ☐Asian ☐Islander
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific
- ☐ Unknown or decline

Insurance: _____ Policy #: _____

Medicare #: _____ Medicaid #: _____

Medical Doctor: _____ Date of last visit: ____/____/____

Spouse's Name:_____

Pharmacy name: _____ Phone: _____

Employer: _____ Position: _____

Emp. Address: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Relationship: _____

Address: _____Apt: _____City: _____ Zip: _____

Home Ph: (___) _____Work Ph: (____) _____Cell.Ph: (____) _____

Responsible Party (use "same" when applicable)

Name of person responsible for account: _____

SSN: _____ DOB: ____/____/____

Address: _____Apt #: _____City: _____ Zip: _____

Home Ph: (___) _____Work Ph: (____) _____Cell.Ph: (____) _____

How did you hear about our office? _____

Is our patient? ____ yes ____ no Name: _____