



PATIENT INFORMATION

DATE ____/____/____

PATIENT NAME: LAST _____ FIRST _____ MIDDLE _____

DATE OF BIRTH ____/____/____ SOCIAL SECURITY NUMBER _____

RACE (required information for Patient Protection and Affordable Care Act):

AFRICAN AMERICAN AMERICAN INDIAN ASIAN CAUCASIAN (WHITE) HISPANIC OTHER

PRIMARY CARE PHYSICIAN _____

REFERRING PHYSICIAN (IF DIFFERENT FROM PRIMARY CARE PHYSICIAN) _____

HOW DID YOU HEAR ABOUT US _____

RELATIONSHIP STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOWED DOMESTIC PARTNER

HOME ADDRESS: _____

CITY _____ STATE _____ ZIP CODE _____

HOME PH. (____) ____-____ WORK PH. (____) ____-____ EXT. _____

CELL PH. (____) ____-____ BEST NUMBER TO REACH YOU: _____

EMAIL ADDRESS: (All email addresses will remain confidential): _____

PATIENT'S EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____

EMERGENCY CONTACT NAME _____ PHONE (____) ____-____

PREFERRED PHARMACY NAME _____

PREFERRED PHARMACY ADDRESS _____

PREFERRED PHARMACY PHONE NUMBER (____) ____-____

BILLING INFORMATION

RESPONSIBLE PARTY NAME _____ PHONE (____) ____-____

ADDRESS _____

DATE OF BIRTH ____/____/____ RELATIONSHIP TO PATIENT _____

INSURANCE COMPANY _____ ID / POLICY NUMBER _____

GROUP NUMBER _____ PAYER ID NUMBER _____

DO WE HAVE PERMISSION TO LEAVE DETAILED MESSAGES ON YOUR VOICEMAIL? YES NO

SIGNATURE: _____ BEST NUMBER TO LEAVE MESSAGES: (____) ____-____

PATIENT/GUARDIAN SIGNATURE _____ **DATE** ____/____/____