PATIENT INFORMATION Mr.___ Mrs.___ Other________

Name ____
First Middle Last Suffix

Address____
Street City State Zip

Date of Birth ______/______/__________ Is Patient a Minor? Y N Gender: Male / Female

Preferred Contact Method: Home Cell ________________________ Ok to leave message? Y N

Backup Contact Method: Home Cell ________________________ Ok to leave message? Y N

Social Security Number: ____

E-mail address: ____
In the future may we confidentially communicate with you through this email address? Y N

Referred By: Doctor________________ Friend/Relative__________________ Other________________________

Primary Care Physician: ______________________________ Phone: ___________________________

Race: ☐African American ☐American Indian/Alaska Native ☐Asian ☐Pacific Islander ☐White ☐Decline to state

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Ethnicity: ☐Hispanic/Latino ☐Non Hispanic ☐Decline to state Pref Language:_________________

Empl Status: ☐Employed ☐Student ☐Homemaker ☐Retired ☐Unemployed

Employer Name/Address: ____

☐Check here if employer is for parent of a minor.

RESPONSIBLE PARTY:

Name: ______________________________________ Relationship to Patient:____________________________

Address: ____Phone: ___________________________________

EMERGENCY CONTACT:

Name: ______________________________________ Relationship to Patient: ____________________________

Phone 1: ____________________________________ Phone 2: _______________________________________

Patient Signature: ____ Date: _____________________________