Patient information

Last name:_____ First name:_____ M.I._____
Street Address:_____ Apt#_____
City:_____ State:_____ Zip Code:_____
Home phone:_____ Cell:_____
Work_____ EXT:_____ Email:_____
Birth Date:_____ Social Security #:_____
Employer:_____ Phone:_____
Occupation:_____
Gender: □Male □Female Marital Status: □Married □Single □Divorced □Widowed
Spouse/Partner Name: _____ SS#: _____
Spouse/Partner DOB: _____ Phone #:_____
Minors Only: are parents __Married __Divorced Custodial Parent:_____
Custodial Parent #: (_____)_____-_____ Work #: (_____)_____-_____
Custodial Parent SS#: _____ DOB: _____

Race

□Hispanic □Asian or Pacific Islander
□White □Black
□American Indian or Alaska Native
□Native Hawaiian or Other Pacific Islander

Ethnicity

□Hispanic or Latino □Native Hawaiian or Other Pacific Islander
□Caucasian □Two or More Races
□Asian
□Black or African American
□American Indian or Alaska Native

□Prefer not to answer

Emergency Contact

Name:_____ Relation:_____
Home phone:_____ Cell:_____

Preferred Pharmacy

Name:_____ Address:_____

Is this visit accident related?: __Yes __No If yes, Injury date: _____

Work Related: _____ Motor Vehicle: _____ Other Injury: _____

*NOTE: we do not bill MVA or Attorney unless you have Medicare or Medicaid (regardless of fault)

Insurance

Primary Insurance Name:_____ Effective Date:_____
Policy Holder's Last name:_____ First name:_____ M.I._____
Birth Date:_____ Relationship to Patient:_____

Secondary Insurance Name:_____ Effective Date:_____
Policy Holder's Last name:_____ First name:_____ M.I._____
Birth Date:_____ Relationship to Patient:_____

Patient's Signature (OR Parent if patient is a Minor): _____ Date: _____