

PLEASE COMPLETE IN BLACK OR BLUE INK

DATE: _____

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

SOCIAL SECURITY #: _____ BIRTHDATE: _____ SEX: M F

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____

DAYTIME PHONE #: _____ Is this a work #? Yes No *If yes, please list Employer below.

CELL PHONE #: _____

DRIVER'S LICENSE #: _____ STATE: _____

MARITAL STATUS: MARRIED SINGLE WIDOWED SEPARATED DIVORCED

SPOUSE'S NAME: _____ PHONE #: _____

RACE: African-American Asian Caucasian Hispanic Other _____

LANGUAGE SPOKEN: _____ VETERAN: Yes No

FAMILY DOCTOR (PCP): FIRST _____ LAST _____ CITY: _____

PHARMACY: _____ STREET: _____ CITY: _____

*EMPLOYER: _____ ADDRESS: _____

WHO REFERRED YOU TO OUR OFFICE: _____

In Case of Emergency, please list a Family Member or Friend **NOT LIVING WITH YOU**:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

STREET ADDRESS: _____ CITY: _____ STATE & ZIP: _____

◆ Please select your **preferred** contact number for appointment call reminders.

HOME #: _____

CELL#: _____ This may include text messages.

WORK#: _____

◆ Our office utilizes a "Patient Portal", an online website patients can access their health information, appointments, medication requests and communicate via a secure email system with our practice. Please list your email address:

Email _____

INSURANCE INFORMATION - Please bring your insurance card(s) & photo ID to Appointment

X _____
SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)