Patient Information Form

*Account #*_____

Today's Date _____

Patient Name: First_____MI____ Last_____SSN _____

Address: Street_____City_____State_____Zip_____

Phone: Home_____Work_____Mobile_____

Date of Birth _____ **E-mail address**_____

What is your preferred method of contact? ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ E-Mail

Race: African-American/ Caucasian/ Asian / Native American /Pacific Islander / none **Ethnicity:** Latino/ Hispanic /Non-Latino

Patient Employed By_____**Occupation**_____**Phone**_____

Address: Street_____City_____State_____Zip_____

Sex: Male/ Female **Marital Status:** Married/ Single/ Divorced/ Separated/ Widowed

Referred by _____ **Primary Care Doctor** _____ **Pharmacy**_____

In case of emergency, who should be notified?_____

Relationship to Patient_____**Home Phone**_____**Mobile Phone**_____

Is the patient a Minor? ☐Yes ☐No **Full-time Student** ☐ Yes ☐ No **Name of School**_____

Name of Responsible Party: First_____Last_____

Date of Birth_____**Relationship to Patient** ☐Self ☐ Spouse ☐ Parent ☐ Other_____

If patient is a Minor, primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Address: *(if different from patient)* Street_____City_____State_____Zip_____

Phone: Home_____Work_____Mobile _____

Employer *(if different from above)*_____**Occupation**_____**Phone**_____

Address: Street_____City_____State_____Zip _____

Insurance Information

Primary Insurance_____

Who Carries the Insurance_____**Date of Birth**_____**ID Number**_____

Patient Relationship to Insured_____

Our practice IS / IS NOT (circle one) a contracted provider with your benefit plan.

Secondary Insurance_____

Who Carries the Insurance_____**Date of Birth**_____**ID Number**_____

Patient Relationship to Insured_____

Signature_____Date_____