

PATIENT INFORMATION

(Please Print)

Today's Date ____/____/____

Name _____

Date of Birth ____/____/____ Age ____ Sex ____ Marital Status _____

Mailing Address _____
City State Zip

Home Phone _____ Work Phone _____ Cell _____

Is it ok to leave a detailed message at any of the above numbers? Yes ____ No ____ (Home, Work, Cell)

Email _____

Preferred Method of contact: Phone (Home, Work, Cell) Email Mail Patient Portal

PARENT, or EMERGENCY CONTACT

Name _____
Last First M.I.

Address _____
City State Zip

Home Phone _____ Work Phone _____
Area Code Area Code

INSURANCE INFORMATION (Please present insurance card and Driver's License at time of check in.)

Policy Holder _____ Male ____ Female ____

Policy Holder's Date of Birth ____/____/____

Policy Holders Address: _____

Relationship of patient to the Insured _____

Pharmacy of choice _____ Phone _____

Name of Referring Physician: _____ Phone _____

Mailing Address _____
City State Zip

Primary Care Physician _____ Phone _____

Mailing Address _____
City State Zip

Ethnicity: (circle which apply) Hispanic/Latino Not Hispanic/Latino Decline to answer

Race: (circle which apply) American Indian/Alaskan Native Asian White Black/African American

Decline to answer

Preferred Language: _____

Place of Birth: _____

Patient or Responsible Party Signature _____ **Date** ____/____/____