



Patient Information

Patient Primary Care Physician: _____

Last name: _____ First: _____ Mid: _____

D.O.B.: ___/___/___ Sex: Male Female SSN: _____ - _____ - _____

Siblings: _____

Address Line 1: _____ Primary phone: Home Cell

Address Line 2: _____ Home phone: (____) _____ - _____

City: _____ State: _____ ZIP: _____ Cell phone: (____) _____ - _____

Mother/legal guardian Relation: _____

Last name: _____ First: _____ Mid: _____

D.O.B.: ___/___/___ Sex: Male Female SSN: _____ - _____ - _____ Marital status: _____

Address Line 1: _____ Primary phone: Home Cell

Address Line 2: _____ Home phone: (____) _____ - _____

City: _____ State: _____ ZIP: _____ Cell phone: (____) _____ - _____

Ok to leave message: Y / N

Employer: _____ Occupation: _____

Address: _____ Email: _____

City: _____ State: _____ ZIP: _____ Work phone: (____) _____ - _____

Father/legal guardian Relation: _____

Last name: _____ First: _____ Mid: _____

D.O.B.: ___/___/___ Sex: Male Female SSN: _____ - _____ - _____ Marital status: _____

Address Line 1: _____ Primary phone: Home Cell

Address Line 2: _____ Home phone: (____) _____ - _____

City: _____ State: _____ ZIP: _____ Cell phone: (____) _____ - _____

Ok to leave message: Y / N

Employer: _____ Occupation: _____

Address: _____ Email: _____

City: _____ State: _____ ZIP: _____ Work phone: (____) _____ - _____

Emergency contact (other than parent or legal guardian) Relation: _____

Last name: _____ First: _____ Mid: _____

Address: _____ Home phone: (____) _____ - _____

City: _____ State: _____ ZIP: _____ Cell phone: (____) _____ - _____

Patient

Race: American indian/Alaska native Asian Black or African american Hispanic White Other

Ethnicity: Non-hispanic Hispanic/Latino Refused to report

Preferred language for healthcare discussion: English Spanish Other _____

Insurance information (primary)

Insured's last name: _____ First: _____ MI: _____
Relationship to patient: _____ D.O.B.: ___/___/____ SSN: ___ - ___ - ___
Insured address: _____ Phone: (___) ___ - _____
City: _____ State: _____ ZIP: _____
Insurance name: _____ Effective date: ___/___/____
Employer name: _____

Insurance information (secondary)

Insured's last name: _____ First: _____ MI: _____
Relationship to patient: _____ D.O.B.: ___/___/____ SSN: ___ - ___ - ___
Insured address: _____ Phone: (___) ___ - _____
City: _____ State: _____ Zip: _____
Insurance name: _____ Effective date: ___/___/____
Employer name: _____

Pharmacy

1) Name: _____ Phone: (___) ___ - _____
Address: _____
2) Name: _____ Phone: (___) ___ - _____
Address: _____

Preferred communications

Phone call: <input type="checkbox"/>	Type of reminders/Follow-up:
Text messaging: <input type="checkbox"/>	Select all <input type="checkbox"/>
Preferred phone: (___) ___ - _____	Appointments <input type="checkbox"/>
Preferred language: <input type="checkbox"/> English <input type="checkbox"/> Spanish	Lab results <input type="checkbox"/>
Preferred time to call: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	Health maintenance <input type="checkbox"/>
Send reminder/Follow-up letters: <input type="checkbox"/>	Rx confirmation <input type="checkbox"/>
Send reminder/Follow-up emails: <input type="checkbox"/>	General notification <input type="checkbox"/>

Parent/legal guardian signature Relationship Date