

Date: \_\_\_\_\_

PATIENT INFORMATION						
Name (Last, First, Middle):			SSN#	Birthdate	Age	Sex
Mailing Address			City, State, Zip			
Home Phone		Cell Phone		Email Address		
Marital Status	Student Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Smoker? Yes or No	Veteran (Y/N)?	Ethnicity: Hispanic or Non-Hispanic	Primary Care Physician	
Referring Physician		Referring Physician Contact #	Other Medical Providers			
Race ( <b>Circle Answer</b> ): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White					Language	
Emergency Contact Name			Emergency Contact Phone #s Hm: _____ Cell: _____			
Employer Name and Address				Work Phone #		
If patient is a minor, please fill out this portion						
Parent or Guardian's Name:			Parent or Guardian's Phone #s Hm: _____ Wk: _____ Cell: _____			
RESPONSIBLE PARTY INFORMATION (if different from above)						
Name (Last, First Middle)			SSN#	Birthdate	Sex	
Address			City, State, Zip			
Home Phone	Cell Phone	Work Phone	Relationship to patient			
PRIMARY INSURANCE						
Name of Insurance Company		Name of Insured		Address of Insured (if different than address above)		
Insured's Birthdate		Insured's SSN #		Insured's Insurance ID #		Relationship to patient
SECONDARY INSURANCE (if applicable)						
Name of Insurance Company		Name of Insured		Address of Insured (if different than address above)		
Insured's Birthdate		Insured's SSN#		Insured's Insurance ID #		Relationship to patient
Workers Compensation						
Are you here for workers compensation YES _____ NO _____ Date: _____						
Accident						
Auto <input type="checkbox"/>		Work <input type="checkbox"/>		Other <input type="checkbox"/>		Date of Accident:
Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan)				Yes _____ No _____		
Do you have a Power of Attorney?				Yes _____ No _____		
If yes to the above questions please make sure we have a copy for your medical record.						