WELCOME TO OUR OFFICE

PATIENT INFO

Mr. Mrs. Ms. _____
Last Name First Middle Initial Parent / Guardian / Other

Home Address: _____
Street City State Zip

Home Phone: (____) _____ Date of Birth: __/__/__ Age: ____ SS#_____

Cell Phone: (____) _____ Texting okay? Y / N E-mail: _____

Employer: _____ Business Address: _____

Occupation: _____ Business Phone: (____) _____

Marital Status (circle) M / S / Div / Wid If married, name of spouse: _____

Whom should we contact in case of an emergency? _____ (____) _____
Name/ Relation Phone

How did you hear about us? _____ If referred by a doctor, Name/City: _____

INSURANCE

Primary Insurance Company: _____ Mailing Address: _____

Member ID #: _____ Group ID #: _____

Name of Primary Insured: _____ Date of Birth: ____/____/____

Primary Insured's Employer: _____ Business Phone: (____) _____

Secondary Insurance Company: _____ Mailing Address: _____

Member ID #: _____ Group ID #: _____

Name of Primary Insured: _____ Date of Birth: ____/____/____

DEMOGRAPHICS

In order to improve the quality, safety, and efficiency of patient care with the use of electronic health records, please circle:

Preferred Language: English / Spanish / Polish / Other _____

Race: African Am / Asian / Hispanic / White / Other _____

Ethnicity: Hawaiian or Pacific Islander / Hispanic or Latino / Not Hispanic/Latino

Communication Preference: Email / Postal / Telephone