PATIENT INFORMATION (**please fill in completely**) DATE_____

PATIENT NAME_____ BIRTHDATE_____
First middle last AGE_____

PATIENT'S SOCIAL SECURITY #_____ MALE_____ FEMALE____

PATIENTS HOME PHONE_____**WORK PHONE**_____

ETHNICITY **__Hispanic or Latino __Not Hispanic or Latino**

Race-Check all that apply __American Indian or Alaskan Native __Asian __Black or African American__ Native Hawaiian or Other Pacific Islander ___White
PREFERRED LANGUAGE _____

PREFERRED METHOD OF COMMUNICATION ___ Letter __Cell phone ___May leave message___ Cell Phone___ Do Not leave Message___

_____ SOCIAL SECURITY #_____
PERSON RESPONSIBLE FOR BILL

Marital Status ___Married ___Divorced
___ Single ___ Separated
___ Widow ___ Widower

_____
RELATIONSHIP TO PATIENT

_____ CELL PHONE_____
AREA CODE & HOME PHONE

_____
ADDRESS STREET APT # CITY STATE ZIP CODE

_____
EMPLOYED BY EMPLOYERS ADDRESS OCCUPATION BUS. PHONE

_____
SPOUSE'S NAME EMPLOYER EMPLOYERS ADDRESS BUS. PHONE

_____
NEAREST RELATIVE/FRIEND NOT LIVING WITH YOU TELEPHONE

Family Doctor/Pediatrician_____
Patient Referred By PHYSICIAN_____ YELLOWPAGES___FRIEND__

MEDICAL INSURANCE

Name of Company_____ Name of Company_____
Subscriber Name_____ Subscriber Name_____
Copay Amount_____ Copay Amount_____
Subscriber No._____ Subscriber No._____
Group No._____ Group No._____
Subscriber Birthdate_____ Subscriber Birthdate_____

REASON FOR SEEING DOCTOR_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN_____