

Physician \_\_\_\_\_ Appt. Date \_\_\_\_\_ Appt. Time \_\_\_\_\_

PATIENT INFORMATION (please print)					
LAST NAME		FIRST NAME		MIDDLE NAME	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	SOCIAL SECURITY NUMBER		DATE OF BIRTH	
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino			RACE		
PREFERRED LANGUAGE			PRIMARY CARE PROVIDER		
PATIENT'S ADDRESS					
ZIP	CITY	STATE	COUNTY		
MOBILE PHONE	HOME PHONE	PREFERENCE FOR REMINDERS, BILLING AND OTHER IMPORTANT COMMUNICATIONS: <input type="checkbox"/> Text <input type="checkbox"/> Voicemail <input type="checkbox"/> Email			
EMAIL ADDRESS			Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D		
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Student <input type="checkbox"/> Other					RETIREMENT/DISABILITY DATE
EMPLOYER/SCHOOL					
EMPLOYER/SCHOOL ADDRESS				EMPLOYER/SCHOOL PHONE NUMBER	
REASON FOR VISIT				Advanced Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No	

ENCOUNTER INFORMATION (please print)	
DATE & TIME OF ACCIDENT/INJURY	
Is this due to a Motor Vehicle Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this due to a Workman's Comp? <input type="checkbox"/> Yes <input type="checkbox"/> No

GUARANTOR (if patient is a MINOR - info for person receiving Billing Statement)					
NAME			SOCIAL SECURITY NUMBER		
DATE OF BIRTH		RELATIONSHIP TO PATIENT			
ADDRESS			EMAIL ADDRESS		
ZIP	CITY	STATE	COUNTY		
MOBILE PHONE	HOME PHONE	Preference: <input type="checkbox"/> Mobile <input type="checkbox"/> Home			
EMPLOYER		EMPLOYER PHONE NUMBER			

PRIMARY INSURANCE INFORMATION (Please provide the Front Desk with Insurance Card.)			
SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SUBSCRIBER'S HOME ADDRESS			
EMPLOYER		EMPLOYER PHONE	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time

SECONDARY INSURANCE INFORMATION (Please provide the Front Desk with Insurance Card.)			
SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SUBSCRIBER'S HOME ADDRESS			
EMPLOYER		EMPLOYER PHONE	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time

EMERGENCY CONTACTS			
NAME		DATE OF BIRTH	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
PRIMARY PHONE NUMBER		RELATIONSHIP TO PATIENT	
NAME		DATE OF BIRTH	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
PRIMARY PHONE NUMBER		RELATIONSHIP TO PATIENT	