

Mr./Mrs./Ms./Dr.: _____ Age: _____
Last First MI

Address: _____
Street City State Zip

Date of Birth: _____ Social Security # _____ Marital Status _____ Sex _____

Home Phone: _____ Work Phone: _____ Cell # _____

Person to be contacted in case of an emergency:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Language: _____ Ethnicity: _____

Smoking Status: (check one)

___ Current: Everyday

___ Current: Some days

___ Former smoker

___ Never smoked

___ Status Unknown

Race: (check one)

___ White

___ Black

___ Alaska Native

___ Native Hawaiian or other Pacific Island

___ Other: _____

___ European

___ Asian

___ Arab

___ Hispanic/Latino

___ American Indian

Referring Physician (if any): _____

Address: _____
Street City State Zip

Phone: _____

Do you wish to have any reports go to any other Physician: Yes ___ No ___

Name: _____ Address: _____

Do you wish to have your condition or laboratory results discussed with anyone other than yourself and your referring physician? Yes ___ No ___ If yes, list names below. Please indicate no more than two.

How did you hear about our practice?: _____

PATIENT NAME: _____

Insurance Carrier: _____

ID/Policy #: _____ Group Name/Number _____

Insured's Name: _____ Relationship: _____ DOB: _____

Mailing Address: _____

Do you have additional insurance? Yes___ No___ (If yes complete 1-5)

1. Carrier: _____

2. ID/Policy # _____ 3. Group Name&# _____

4. Insured's Name _____ 5. Relationship: _____

6. Insured's DOB: _____

I agree to be personally responsible for all charges incurred for my medical care.

Patient Signature: _____ Date: _____

Responsible Party: _____ Date: _____