PATIENT INFORMATION

Name: ____
Date: ____
Birthdate: ____
SS#: ____
Home Address: ____
City: _____________________________ State: ______ Zipcode: __________
Home phone: ______________________ Cell phone: ___________________________
Work phone: _______________________ Other phone: ___________________________
Email: ____
Preferred method of contact: ____
Referred by: _____________________________________
Occupation: _____________________________________

Marital status: ☐single ☐married ☐divorced ☐separated ☐widowed.
Spouse's name: ___________________________________

Race: ☐ White ☐ Hispanic or Latino ☐ Black or African American
☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino
Preferred Language: ☐ English ☐ Spanish ☐ Other (specify):

Insurance Information

Company name: ____
Phone number: ____
Insured's name: ____
Relation: ______________ Date of birth: _____________
Insured's ss#: ____
Member ID #: ____
Group #: ____

Emergency contact information

Who should we contact: ___________________________________
Relation: ___________________________________
Home phone number: ___________________________________
Work phone number: ___________________________________

I consent to receiving text/voice/unencrypted e-mail messages ☐ Yes

____________________________________ ______________________________
Patient Signature Date