PATIENT INFORMATION SHEET

THIS FORM MUST BE FILLED OUT LEGIBLY AND IN FULL

PATIENT NAME:_____ DOB:_____ SS#:_____-_____-_____

RACE (OPTIONAL): American Indian/Alaskan Native Asian Black/African-American Hawaiian/Pacific Islander White Other Decline/Refuse to Answer/Unknown

ADDRESS:_____
STREET CITY ZIP

MOTHER'S MAIDEN NAME:_____ PREFERRED PHARMACY:_____
NAME STREET/TOWN

PRIMARY PARENT/GUARDIAN:_____ DOB:_____ SS#:_____

RELATIONSHIP TO PATIENT: _____ Address same as patient? Y / N

If no:_____Email address:_____
STREET CITY ZIP

Primary Phone#: (___)-_____-_____ Secondary Phone#: (_____)-_____-_____ WORK PHONE: (____)-_____-_____

ALTERNATE PARENT/GUARDIAN:_____ DOB:_____ SS#:_____

RELATIONSHIP TO PATIENT: _____ Address same as patient? Y / N

If no:_____Email address:_____
STREET CITY ZIP

Primary Phone#: (___)-_____-_____ Secondary Phone#: (_____)-_____-_____ WORK PHONE: (____)-_____-_____

EMERGENCY CONTACTS

Name:_____Relationship to Patient:_____Ph #: (___)-_____-_____

Name:_____Relationship to Patient:_____Ph #: (___)-_____-_____

BILLING INFORMATION

Primary Insurance Company: _____Policy ID#:_____Group #:_____

Policy Holder's Name:_____DOB:_____ SS#:____-_____-_____

Employer:_____ Address same as patient? Y / N

If no:_____
STREET CITY ZIP

Secondary Insurance Company:_____Policy ID#:_____Group #:_____

Policy Holder's Name:_____DOB:_____ SS#:____-_____-_____

Employer:_____ Address same as patient? Y / N

If no:_____
STREET CITY ZIP

Form filled out by:_____ Relationship to patient:_____ Date:_____

Please designate who you would prefer as your Primary Care Provider:_____

OFFICE USE ONLY

Date rec'd_____
Date entered_____
Initials:_____