

\*\*\*\* All Fields Must Be Completed \*\*\*\*

PATIENT INFO

Date: \_\_\_\_\_ Social Security # : \_\_\_\_\_  
 First Name: \_\_\_\_\_ MI \_\_\_\_\_ Last: \_\_\_\_\_ Suffix: \_\_\_\_\_  
 Sex: M / F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 (Please circle one)  
**Marital Status:** Single Married Divorced Widowed Legally Separated  
**Nationality:** African Amer. Amer. Indian Asian Caucasian Hispanic Other  
**Ethnicity:** Latino/Hispanic Other Refused  
**Primary Language:** \_\_\_\_\_

PATIENT INFO CONT.

<b>Patient's Permanent Address</b>	<b>Employment status:(Please Circle One)</b>
Address: _____	EMPLOYED SELF EMPLOYED RETIRED DISABLED UNEMPLOYED STUDENT
Address: _____	Employer Name _____
City: _____	Address: _____
State: _____ Zip: _____	City: _____
<b>Please Circle Preferred Number for Primary Communication</b>	State: _____ Zip: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Home Phone: _____
E-mail Address: _____	Work Phone: _____
<b>Write in <u>NONE</u> if no e-mail address is available</b>	

Who is your Primary Care Doctor: \_\_\_\_\_  
 Who can we thank for referring you today? (Please circle one) Referral Svc Walk-In Provider Directory Friend Website  
 Referring Physician: \_\_\_\_\_ Self Referred Billboard Other \_\_\_\_\_

GT INFO

Financial Responsible Party or Guarantor Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

INSURANCE INFO

<b>Primary Carrier:</b>	<b>Secondary Carrier:</b>
Subscriber: _____	Subscriber: _____
Subscriber DOB: _____	Subscriber DOB: _____
Subscriber ID #: _____	Subscriber ID #: _____

EMR CONT. INFO

Name: \_\_\_\_\_ Relationship to pt: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

EXTENDED INFORMATION

Who is the legal guardian for the patient? Please circle one: **Self** or **Other**  
 \* If other is selected please print name and phone number  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Smoker? Please circle one: **Current Smoker** **Former Smoker** **Never Smoked**  
 Do you have a visual impairment that would hinder you from reading written materials from your physician?  
 Please circle one: **Yes** or **No**  
 Do you have a hearing impairment that would impede verbal communication with your provider?  
 Please circle one: **Yes** or **No**