Patient Information

Today's Date: ________________________ My appointment is with: ____________________________

Name____

Last Name First Name Middle Name Maiden Name

Preferred Name: ____

Address____

Street City & State Zip Code

Home Phone ______________________________ Cell Phone ___________________________

DOB: ________________________________ Marital Status: S M W D

Occupation:

____________________________________ Work Phone: ______________________

Employer Name & Address

____

Spouse/Partner Name _____________________________________ DOB: _______________

Home/Cell Phone ___________________________ Work Phone__________________________

Spouse/Partner's Employer & Address:

____

Primary Care Provider: Referred by:

_______________________________________ ____________________________________

In case of emergency contact:

_______________________________Phone ________________ Relationship: _____________

Release of Medical Information:

_______________________________Phone ________________ Relationship: _____________

_______________________________Phone ________________ Relationship: _____________

Patient Portal Access:

Email: ____

Appointment reminders/or prescription refills: Notify by □ text □ phone call

---

To meet government requirements, please answer the following three questions:

Race: White, Asian, Black or African American, Hispanic, American Indian, Other, Decline

Ethnicity: Hispanic or Latin, Not Hispanic or Latin, Decline

Privacy Notice: Acknowledge of Receipt of Notice of Privacy Practices:

Name of Patient: ____

___ The individual Declines a copy of the Privacy Policy ___ The individual Received a copy of the Privacy Policy

Staff Initials _____