



PLEASE PRINT AND ANSWER ALL QUESTIONS

PATIENT INFORMATION			
<u>NAME (FIRST & LAST):</u>		<u>DATE OF BIRTH:</u>	<u>SOCIAL SECURITY NUMBER:</u>
<u>PREFERRED LANGUAGE OF MEDICAL INFORMATION:</u>		<u>DO YOU NEED A FREE INTERPRETER / TRANSLATOR?:</u> YES NO	
<u>GENDER:</u> (CIRCLE ONE) MALE FEMALE	<u>MARITAL STATUS:</u> (CIRCLE ONE) MARRIED SINGLE DIVORCED LIFE PARTNER SEPARATED WIDOWED OTHER:		
<u>RACE:</u> (CIRCLE ONE) WHITE BLACK / AFRICAN AMERICAN ASIAN NATIVE HAWAIIAN PACIFIC ISLANDER AMERICAN INDIAN OR ALASKAN NATIVE DECLINE TO SPECIFY			
<u>ETHNICITY:</u> (CIRCLE ONE) HISPANIC / LATINO NON-HISPANIC / LATINO DECLINE TO SPECIFY			
<u>STREET ADDRESS:</u>			
<u>CITY:</u>	<u>STATE:</u>	<u>ZIP CODE:</u>	<u>COUNTY:</u>
<u>HOME PHONE:</u>	<u>CELL PHONE:</u>	<u>WORK PHONE:</u>	
<u>EMAIL ADDRESS:</u> (USED FOR SATISFACTION SURVEYS, STATEMENTS, & APPOINTMENT REMINDERS)			
<u>PREFERRED CONTACT METHOD:</u> (CIRCLE ONE) HOME # WORK # CELL # EMAIL TEXT MAIL / LETTER			
EMERGENCY CONTACT			
<u>NAME (FIRST & LAST):</u>		<u>RELATIONSHIP TO PATIENT:</u>	
<u>HOME PHONE:</u>	<u>CELL PHONE:</u>	<u>WORK PHONE:</u>	
MUST COMPLETE IF UNDER 18 OR USING GUARDIAN'S INSURANCE			
<u>FATHER'S NAME:</u>		<u>MOTHER'S NAME:</u>	
<u>DATE OF BIRTH:</u>		<u>DATE OF BIRTH:</u>	
<u>SOCIAL SECURITY NUMBER:</u>		<u>SOCIAL SECURITY NUMBER:</u>	
<u>PHONE NUMBER:</u>		<u>PHONE NUMBER:</u>	