

PATIENT INFORMATION FORM - THIS FORM MUST BE FULLY COMPLETED - PLEASE PRINT

Patient Name: _____
(Last) (First) (M.I.) (Nickname)

Birth Date: _____ **Age:** _____ **Gender:** M F **Marital Status:** S M D W **Social Security #:** _____

**Race:	American Indian or Alaska Native Black or African American	Asian Hispanic or Latino	Native Hawaiian or Other Pacific Islander White Decline to Answer
Ethnicity:	Hispanic or Latino	Non Hispanic or Latino	Decline to Answer
Language Preferred:	English	Spanish	Other _____

****Data collection and classification are from the Centers for Medicare Services (CMS)**

Mailing Address: _____
City State Zip

Home Phone: () _____ **Work Phone:** () _____

Cell Phone: () _____ **E-mail:** _____

Employer/School: _____ **Occupation:** _____
City State Zip

Name of Referring Physician or Primary Care Physician: Dr. _____ **Phone #:** _____

In case of emergency who should be notified _____ **Phone #:** _____ **Relationship:** _____

RESPONSIBLE PARTY INFORMATION: (TO BE COMPLETED FOR MINORS ONLY)

Responsible Party Name: _____
(Last) (First) (M.I.)

Address: _____ **Phone #:** _____
City State Zip

Birth Date: _____ **Age:** _____ **Social Security #:** _____ **Relationship to Patient:** _____

PRIMARY INSURANCE TO FILE / SUBSCRIBER'S INFORMATION: * HMO (Referral Required) PPO**

Insurance Company Name: _____ **Address:** _____

Policy / ID#: _____ **Group #:** _____

Subscriber's Name: _____ **Birth Date:** _____ **Relationship to Patient:** _____

Subscriber's Address: _____ **Phone #:** _____
City State Zip

SECONDARY INSURANCE TO FILE / IS PATIENT COVERED BY ADDITIONAL INSURANCE: * HMO PPO**

Insurance Company Name: _____ **Address:** _____

Policy / ID#: _____ **Group #:** _____

Subscriber's Name: _____ **Birth Date:** _____ **Relationship to Patient:** _____

Subscriber's Address: _____ **Phone #:** _____
City State Zip

I VERIFY THAT THE INFORMATION IS CORRECT.

X _____ **Relationship to Patient** _____ **Date** _____
Signature of Patient, Parent / Guardian or Personal Representative