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	Asian	Native Hawaiian or Other Pacific Islander
	Black or African American	Hispanic or Latino	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