Today’s Date: PCP:

**Patient Information**

**Patients Last Name: First: Middle: SSN: Birthdate: Sex:**

**/ /  M  F**

**Race:** (Optional but ensures Quality of care)  
American Indian/Alaskan Native Asian Black/African American Native Hawaiian/ Pacific islander White  
**Ethnicity:** (Optional but ensures Quality of care) **Language Preference:**  
 Hispanic/Latino  Not Hispanic/Latino  English  Spanish Other:

**Marital Status** (circle one) **Home Phone: Mobile Phone: Work Phone:**  
Single/ Mar/ Div/ Sep/ Wid **( ) ( ) ( )**

**Email Address: Preferred Contact Method** (select only one):  
  Home  Mobile  Work  Email  Mail

**Street Address:**

**City: State: Zip Code:**

**Occupation: Employer:**

**In Case Of Emergency**

**Name of local friend or relative: Phone: Relationship to Patient:  
 ( )**

**Grant Access to Your Medical Information  
We may discuss Your health information with the following people (Caregivers, Family members, Etc)**

**Name: Date of Birth: Phone Number: Relationship to patient:**

**/ / ( )**

**/ / ( )**

**Insurance Information**

**Person Responsible for bill: Birth Date: Address (If different) Home Phone:  
 / / ( )**

**Primary Insurance Company:  
Subscriber’s Name: Birthdate Policy ID: Group #: Patients Relationship to subscriber:  
 / /**  Self  Spouse  Child  Other

**Secondary Insurance Company:  
Subscriber’s Name: Birthdate Policy ID: Group #: Patients Relationship to subscriber:  
 / /**  Self  Spouse  Child  Other

**Signature**