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**