**Patient Name: Date of Birth:**

 (First, Middle Initial, Last)

Driver’s License # and State: Soc. Security #:

Primary Phone #: Other Phone #: Work #:

Physical Address: City: State: Zip:

Mailing Address: City: State: Zip:

Employed (Full or Part Time) / Retired / Unemployed / Student Employer:

(CIRCLE ONE)

Employer Address: City: State: Zip:

Patient Email Address: Marital Status: Single / Married / Widowed / Divorced

**Spouse’s Name (or Parent/Guardian if patient is a minor**):

Phone #: Date of Birth: Social Security #:

Employer: Work #:

**Person Responsible for Account (if other than patient):**

Phone #: Date of Birth: Social Security #:

Physical Address: City: State: Zip:

Mailing Address: City: State: Zip:

Employer: Work #:

**In Case of Emergency Contact:** Okay to release information? Y / N

 **(Nearest Living Relative)**

Phone #: Relationship: *Mother / Father / Child / Sig. Other / Spouse / Other:*

 (CIRCLE ONE)

**Second Emergency Contact:** Okay to release information? Y / N

 (Relative –or- Non-Relative)

Phone #: Relationship: *Mother / Father / Child / Sig. Other / Spouse / Other:*

 (CIRCLE ONE)

**Preferences:**

Ethnicity*: Hispanic or Latino / Not Hispanic or Latino / Other / Decline to Answer*

Race: White / NatAm – AkNat / Asian / Black-AfrAm / Hawaiin-Pac / Decline to Answer

Primary Language: English / Spanish / Other: Do you need an interpreter at your visit? Y / N

Do you have any special needs that we should know about to make your visit easier?

***Please present your insurance card to the receptionist. Co-pays are due on the date of service.***

**PRIMARY Insurance Company**: Insured’s Name:

Insured’s DOB: Insured’s Employer:

ID#: Group/Plan #: Relation to Patient:

**SECONDARY Insurance Company**: Insured’s Name:

Insured’s DOB: Insured’s Employer:

ID#: Group/Plan #: Relation to Patient: