PATIENT INFORMATION

Name (*Last, First, Middle Initial*) _____

Gender: *M* ☐ *F* ☐ **Date of Birth**: _____ **Social Security #**: _____

Marital Status: *S* ☐ *M* ☐ *D* ☐ *W* ☐

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

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

Preferred #: *H* ☐ *W* ☐ *C* ☐ **Where may we leave messages for you?** *H* ☐ *W* ☐ *C* ☐

E-mail: _____ **Would you like to receive our Monthly E-Newsletter?** *Y* ☐ *N* ☐

Emergency Contact: *Name* _____ *Phone* (_____)_____

Is this appointment related to a recent accident? *Y* ☐ *N* ☐ **What type of accident?** *Work* ☐ *Auto* ☐ *Other* ☐

Occupation: _____ **Employer**: _____

Spouse/ Parent/ Guardian Name: _____

Spouse/ Parent/ Guardian Date of Birth: _____ **Spouse/ Parent/ Guardian SS#**: _____

Spouse/ Parent/ Guardian Employer: _____

What is your preferred method of communication for private health data? *Home* ☐ *Work* ☐ *Cell* ☐ *e-Mail* ☐ *Mail* ☐

What is your smoking status? *Current, Every Day* ☐ *Current, Some Days* ☐ *Former* ☐ *Never* ☐

What is your ethnicity? *Hispanic or Latino* ☐ *Not Hispanic or Latino* ☐

What is your race? *White* ☐ *Black or African American* ☐ *Asian* ☐ *American Indian or Alaska Native* ☐
Native Hawaiian or Other Pacific Islander ☐ *Other Race* ☐ *More Than One Race* ☐

What is your preferred language? *English* ☐ *Spanish* ☐ *French* ☐ *German* ☐ *Italian* ☐ *Russian* ☐
Portugese ☐ *Chinese* ☐ *Japanese* ☐ *Korean* ☐ *Vietnamese* ☐

Are you currently taking any medications? *Y* ☐ *N* ☐ *If yes, please list*: _____

_____

_____

Are you allergic to any medications? *Y* ☐ *N* ☐ *If yes, please list*: _____

_____

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims by provider or agent. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Patient Signature: _____ Date: _____