PATIENT INFORMATION SHEET

PLEASE PRESENT UP-TO-DATE INSURANCE CARDS TO RECEPTIONIST

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____/_____/_____ SEX: M ☐ F ☐

PATIENT'S NAME: Last_____First_____ MI_____

DO YOU HAVE A LIVING WILL? Y ☐ N ☐

LOCAL ADDRESS: _____ _____City_____State/Zip _____

LOCAL PHONE: _(____)_____ OUT OF STATE PHONE: _(____)_____

CELL PHONE: _(____)_____ eMAIL ADDRESS _____

OUT OF STATE ADDRESS:_____City _____State/Zip _____

EMPLOYER:_____EMPLOYER'S PHONE:_____

MARITAL STATUS: MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐

SPOUSE'S NAME: Last_____First _____ MI_____DATE OF BIRTH: _____/_____/_____

SPOUSE'S SOCIAL SECURITY #:_____

SPOUSE'S EMPLOYER:_____ SPOUSE'S EMPLOYER'S PHONE:_____

EMERGENCY CONTACT INFORMATION:

NAME / RELATION: _____ PHONE #: _____

DUE TO NEW GOVERNMENT GUIDELINES, WE ARE NOW REQUIRED TO ASK THE FOLLOWING INFORMATION:

RACE:

- ☐ AMERICAN INDIAN OR ALASKAN NATIVE
- ☐ ASIAN
- ☐ NATIVE HAWAIIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ WHITE
- ☐ HISPANIC
- ☐ OTHER RACE
- ☐ OTHER PACIFIC ISLANDER
- ☐ UNREPORTED / REFUSED TO REPORT

ETHNICITY:

- ☐ HISPANIC
- ☐ NON-HISPANIC
- ☐ REFUSE TO REPORT

LANGUAGE:

- ☐ ENGLISH
- ☐ OTHER
- ☐ INDIAN (INCLUDES HINDI & TAMIL)
- ☐ RUSSIAN
- ☐ SPANISH

FAMILY PHYSICIAN'S NAME: _____ _____ PHONE:_____
First Last

REFERRING PHYSICIAN'S NAME: _____ _____PHONE: _____
First Last

DOES YOUR DOCTOR NEED TO AUTHORIZE THIS VISIT FOR YOUR INSURANCE? ☐ Y ☐ N