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: ____________ (First) ____________ (Last) PHONE:____________

REFERRING PHYSICIAN'S NAME: ____________ (First) ____________ (Last) PHONE: ____________

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