PATIENT INFORMATION FORM

(PLEASE PRINT)

PATIENT NAME: _____ DATE OF BIRTH: _____

GENDER: Female / Male PATIENT'S SS #: _____
RACE: ___White/Caucasian ___Native American ___Hawaiian Native/Pacific Islander ___Black/African American ___Asian
OTHER: _____
ETHNICITY: ___Hispanic ___Non-Hispanic

Preferred Language: _____

PARENT #1 PHONE: _____
PARENT #2 PHONE: _____

ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

RESPONSIBLE PARTY (Guarantor): _____
Insurance Holder name if Different: _____
INSURANCE COMPANY: _____NUMBER: _____
DOB Of Insured: _____RELATIONSHIP: ___Mother __Father OTHER: _____

PARENT #1: _____ MOTHER / FATHER / GUARDIAN
Email: _____
DOB: _____ SS#: _____
ADDRESS if different:_____
CITY: _____ STATE: _____ ZIP: _____
Place of Employment: _____ PHONE # _____

PARENT #2: _____ MOTHER / FATHER / GUARDIAN
Email: _____
DOB: _____ SS#: _____
ADDRESS if different:_____
CITY: _____ STATE: _____ ZIP: _____
Place of Employment: _____ PHONE # _____

Will we be your PRIMARY CARE PROVIDER or is this a WALK-IN ONLY visit?

Who may we contact other than a Parent/Guardian, In case of Emergency:
_____ Phone #: _____
Relationship to Patient: _____

Additional Family Members Seen In Our Office: _____

HOW DID YOU HEAR ABOUT US? _____