



Last Name _____ First Name _____ MI _____
 Date of Birth _____ Social Security # _____ Sex: ___ Male ___ Female
 Address _____ Zip _____ City _____ State _____
 Home Phone _____ Daytime Telephone _____
 Cell Phone# _____ Email: _____

<u>Marital Status</u>	<u>Employment</u>	<u>Contact Preference</u>	<u>Pref Language</u>	<u>Race</u>	<u>Pt has Legal Guardian</u>
<input type="checkbox"/> Single	<input type="checkbox"/> Full Time	<input type="checkbox"/> Cell Only	<input type="checkbox"/> English	<input type="checkbox"/> American Indian	<input type="checkbox"/> Yes
<input type="checkbox"/> Married	<input type="checkbox"/> Part Time	<input type="checkbox"/> Home Phone	<input type="checkbox"/> Spanish	<input type="checkbox"/> Asian	<input type="checkbox"/> No
<input type="checkbox"/> Divorced	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Work Phone	<input type="checkbox"/> French	<input type="checkbox"/> Black/African Amer.	<input type="checkbox"/> N/A
<input type="checkbox"/> Legally Separated	<input type="checkbox"/> Retired	<input type="checkbox"/> OK to Leave Message	<input type="checkbox"/> Hindi	<input type="checkbox"/> Hispanic/ or Latino	
<input type="checkbox"/> Widowed	<input type="checkbox"/> Student	<input type="checkbox"/> Don't Call at Home	<input type="checkbox"/> Italian	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<u>Communication Barrier</u>
<input type="checkbox"/> Life Partner		<input type="checkbox"/> Don't Call at Work	<input type="checkbox"/> Other	<input type="checkbox"/> White /Caucasian	<input type="checkbox"/> Hearing Impaired
		<input type="checkbox"/> No Preference _____		<input type="checkbox"/> More than one Race	<input type="checkbox"/> Vision Impaired
		<input type="checkbox"/> Other _____		<input type="checkbox"/> Decline to Provide	<input type="checkbox"/> Need an Interpreter

Employer Name _____ Work Telephone: _____
 Emergency Contact: _____ Emergency Contact Phone: _____
 Who is your Primary Care Provider? _____ Phone# _____

RESPONSIBLE PARTY/GUARANTOR INFORMATION - Complete if different than patient information.

Name of person financially responsible _____
 Address _____ City _____ State _____ Zip _____
 Telephone _____ Social Security # _____ Relationship _____

INSURANCE INFORMATION

Primary Insurance Information

Name of Insurance _____ Group # _____
 ID # _____ Name of the person insured _____
 Patient's relationship to insured: ___ Self ___ Child ___ Spouse _____ Insured's Date of Birth _____
 Sex: ___ Male ___ Female Employer _____
 Insured Social Security #: _____ Effective Date of policy _____

Secondary Insurance Information

Name of Insurance _____ Group # _____
 ID # _____ Name of the person insured _____
 Patient's relationship to insured: ___ Self ___ Child ___ Spouse _____ Insured's Date of Birth _____
 Sex: ___ Male ___ Female Employer _____
 Insured Social Security #: _____ Effective Date of policy _____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the undersigned Provider and I am financially responsible for non-covered services. I authorize the Provider to release any information required.

Signature: _____ Date: _____
 Pereg.12.10