



## PATIENT INFORMATION

Patient Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN #: \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Alternate Phone # \_\_\_\_\_ Email address: \_\_\_\_\_

Emergency Contact (Name): \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Employer (Name/Phone #): \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Location of Pharmacy: \_\_\_\_\_

Preferred Language: ☐ English ☐ Spanish ☐ Sign Language ☐ Other \_\_\_\_\_

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown

Race: ☐ White ☐ African American ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ American Indian  
☐ Alaska Native ☐ Black & White ☐ Asian & White ☐ Black & Asian ☐ Unknown/ Refused

If you would like your Personal Health Information to be shared with any other person please fill in the information below. We will ask this person to verify their relationship with you, including your date of birth.

1) \_\_\_\_\_  
Full Name Relationship

2) \_\_\_\_\_  
Full Name Relationship

2) \_\_\_\_\_  
Full Name Relationship

## Insurance Information (Please Provide Office with Insurance Cards)

### Primary Insurance

Insurance Company Name: \_\_\_\_\_ Insured Member Name: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### Secondary Insurance or Vision Plan

Insurance Company Name: \_\_\_\_\_ Insured Member Name: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_