

A.

PATIENT INFORMATION

PATIENT: _____ **SSN:** _____
LAST FIRST MIDDLE

DRIVER'S LICENSE NUMBER: _____ **STATE:** _____ **BIRTH DATE:** ____/____/____

GENDER: M F **MARITAL STATUS:** SINGLE MARRIED WIDOWED SEPARATED DIVORCED

ETHNICITY: HISPANIC OR LATINO OR SPANISH ORIGIN NOT HISPANIC OR LATINO OR SPANISH ORIGIN

RACE: ASIAN BLACK/AFRICAN-AMERICAN CAUCASIAN/WHITE HISPANIC
 NATIVE AMERICAN/ALASKAN NATIVE NATIVE HAWAIIAN/PACIFIC ISLAND OTHER REFUSE

MAILING ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME TELEPHONE: () _____ **CELL PHONE:** () _____

EMPLOYMENT STATUS: EMPLOYED STUDENT RETIRED OTHER

EMPLOYER: _____ **PATIENT'S WORK NUMBER:** _____

PATIENT'S ADDITIONAL PHONE: () _____ **E-MAIL:** _____

EMERGENCY CONTACT NAME: _____ **TELEPHONE:** () _____

EMERGENCY CONTACT RELATIONSHIP: _____

WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS: YES NO

PRIMARY CARE PHYSICIAN: _____ **OB/GYN IF APPLICABLE:** _____

PREFERRED LANGUAGE: ENGLISH SPANISH SIGN LANGUAGE OTHER: _____

B.

GUARANTOR INFORMATION (IF PATIENT IS UNDER 18)

GUARANTOR NAME: _____ **RELATIONSHIP OF PATIENT TO GUARANTOR** CHILD OTHER _____

DRIVER'S LICENSE NUMBER: _____ **STATE:** _____

GUARANTOR MAILING ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

GUARANTOR HOME TELEPHONE: () _____ **GUARANTOR SSN:** _____ **GUARANTOR DOB:** _____

GUARANTOR EMPLOYER: _____ **GUARANTOR WORK TELEPHONE:** _____

C.

**PRIMARY INSURANCE INFORMATION
(IF PROVIDING CURRENT INSURANCE CARD, SKIP C & D)**

NAME OF COMPANY: _____

MEMBER NUMBER / CERTIFICATE NUMBER: _____ **GROUP / PLAN:** _____

POLICY EFFECTIVE DATE: _____

RELATIONSHIP OF PATIENT TO SUBSCRIBER / INSURED: CHILD * OTHER * SELF SPOUSE *
(*IF PATIENT IS NOT THE SUBSCRIBER, PLEASE COMPLETE THE INFORMATION BELOW)

NAME OF SUBSCRIBER: _____ **BIRTH DATE:** ____/____/____

SUBSCRIBER'S EMPLOYER: _____

D.

SECONDARY INSURANCE INFORMATION

NAME OF COMPANY: _____

MEMBER NUMBER / CERTIFICATE NUMBER: _____ **GROUP / PLAN:** _____

POLICY EFFECTIVE DATE: _____

RELATIONSHIP OF PATIENT TO SUBSCRIBER / INSURED: CHILD * OTHER * SELF SPOUSE *
(*IF PATIENT IS NOT THE SUBSCRIBER, PLEASE COMPLETE THE INFORMATION BELOW)

NAME OF SUBSCRIBER: _____ **BIRTH DATE:** ____/____/____

SUBSCRIBER'S EMPLOYER: _____