Date___________

Patient Information

(Please Print)

Name____ Nickname____________________

Phone (_____) ______-_______ Cell (_____) ______-______ Email_______________________

Address________________________________ City_______________ State_____ ZIP_______

Sex (circle) Male Female DOB_____/_____/_______ Age_______ SSN_____-____-_____

Marital Status______________ Spouse's Name___________________ No. of children_____

Individual Responsible for Account (if different from patient)__________________

Primary Care Physician_________________________ Referred by_______________________

Major Complaint ____

____

Employer/Position______________________________ Phone (_____) _____-______ Ext_____

Address________________________________ City_______________ State_____ ZIP_______

Please present your insurance card to the front desk Ins. Co.________________

Insured (leave blank if same)__________________________ Employer__________________

Address________________________________ City_______________ State_____ ZIP_______

Phone (_____) ______-_______ DOB_____/_____/_______ SSN_______-______-__________

Electronic Records information by CMS guidelines:

Race (circle one): White - Caucasian/ Black - African American/ Hispanic/ Asian/

Asian Indian/American Indian/ other________________/I choose not to specify.

Preferred Language (circle one): English/ Spanish/ other________/I choose not to specify

Verification Question (circle only one question, then give answer below to that question)

What is the name of your favorite pet?/ In what city were you born? / What is your favorite movie?

What high school did you attend?/ What is your mother's maiden name?/

On what street did you grow up?/What was the make of your first car?/ When is your anniversary?

Verification Answer to the Chosen question: _________________________________

Answer must be at least 6 character