

PATIENT INFORMATION SHEET

THIS FORM MUST BE FILLED OUT LEGIBLY AND IN FULL

**PATIENT NAME**: DOB: Sex: \_\_\_\_\_\_\_ SS#: - -

RACE (OPTIONAL): American Indian/Alaskan Native Asian Black/African-American Hawaiian/Pacific Islander White Other Decline/Refuse to Answer/Unknown

ADDRESS:

 STREET CITY ZIP

MOTHER’S MAIDEN NAME: PREFERRED PHARMACY:

NAME STREET/TOWN

**PRIMARY PARENT/GUARDIAN**: DOB: SS#:

RELATIONSHIP TO PATIENT: Address same as patient? Y / N

If no: Email address:

 STREET CITY ZIP

Primary Phone#: ( )- - Secondary Phone#: ( )- - WORK PHONE: ( )- -

**ALTERNATE PARENT/GUARDIAN**: DOB: SS#:

RELATIONSHIP TO PATIENT: Address same as patient? Y / N

If no: Email address:

 STREET CITY ZIP

Primary Phone#: ( )- - Secondary Phone#: ( )- - WORK PHONE: ( )- -

**EMERGENCY CONTACTS**

Name: Relationship to Patient: Ph #: ( )- -

Name: Relationship to Patient: Ph #: ( )- -

**BILLING INFORMATION**

Primary Insurance Company: Policy ID#: Group #:

Policy Holder’s Name: DOB: SS#: - -

Employer: Address same as patient? Y / N

If no:

 STREET CITY ZIP

Secondary Insurance Company: Policy ID#: Group #:

Policy Holder’s Name: DOB: SS#: - -

Employer: Address same as patient? Y / N

If no:

 STREET CITY ZIP

Form filled out by: Relationship to patient: Date:

**Please designate who you would prefer as your Primary Care Provider:**

OFFICE USE ONLY

Date rec’d\_\_\_\_\_\_\_\_\_\_\_\_\_

Date entered\_\_\_\_\_\_\_\_\_\_\_\_ Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_