Patient Information Form

Patient Name

Legal First Name | Legal Last Name | Suffix | Preferred First Name

Today's Visit

What is the reason for your visit today? ____

Patient Demographics

Permanent Address | Apt. # | City | State | Zip

Primary Phone # | Social Security # | Gender | Birth Date

Language | Marital Status | Email Address (We will never rent or sell your email address, we value your privacy.)

Local or Alternate Address | Alternate Phone # | Today's Date

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ Mixed Race ☐ White ☐ Other ☐ Refuse to Report

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Refuse to Report

Emergency Contact Information

Contact Name | Phone # | Relationship to Patient

Name of a Relative Not Residing With You | Phone #

Patient Employment Information

Employer Name	Employer Phone #

Responsible Party's Information (if someone other than patient)

Legal Name of Responsible Party	Social Security #	Address	City	State Zip

Medical Insurance Information

Insurance Company	Policy Holder's Name	Policy Holder's Relationship to Patient

Policy Holder's Address	City	State	Zip

Policy Holder's Birth Date	Policy Holder's Social Security #	Policy Holder's Employer