

**PATIENT INFORMATION FORM**

Today's Date: \_\_\_\_\_

**Please complete the following information. All information is strictly confidential.  
(Please print clearly)**

**GENERAL INFORMATION**

Patient's Name \_\_\_\_\_  
(Last) (First) (Middle)

Address \_\_\_\_\_ Zip Code \_\_\_\_\_  
(Street) (City)

Home phone ( ) \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_ Work phone ( ) \_\_\_\_\_

Email address \_\_\_\_\_ Employer \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Volunteer information for government reporting requirements:

Race: African American \_\_\_\_\_ White \_\_\_\_\_ Asian \_\_\_\_\_ Hispanic \_\_\_\_\_ American Indian \_\_\_\_\_ Other race \_\_\_\_\_

Ethnicity: Hispanic or Latin \_\_\_\_\_ Not Hispanic or Latin \_\_\_\_\_ Refused to report \_\_\_\_\_

Language: English \_\_\_\_\_ Spanish \_\_\_\_\_ Russian \_\_\_\_\_ Other \_\_\_\_\_

Name of spouse (or parent) \_\_\_\_\_ Spouse's birth date \_\_\_\_\_

Spouse's cell phone ( ) \_\_\_\_\_ Spouse's work phone ( ) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Referred by \_\_\_\_\_

**MEDICAL INFORMATION**

Reason for today's visit \_\_\_\_\_

Describe any conditions we should know about \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Company \_\_\_\_\_

Insured Name \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_