Patient Information Form

Patient #_____

Please Print

Patient Name_____

Birth Date _____ ☐ Male ☐ Female Home Phone # _____

Address _____

City _____ State _____ Zip Code _____

E-mail _____ Cell Phone # _____

Please Check Appropriate Boxes:

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Widowed

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Person to contact in an Emergency _____

Emergency Contact Phone # _____ Relationship_____

How did you hear about our office? _____

If the patient is a minor:

Responsible Party Name: _____

Relationship to patient _____ Home Phone # _____

Address _____

City _____ State _____ Zip Code _____

Birthdate _____ Is this person currently a patient in our office ☐ Yes ☐ No

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

_____ _____

Signature of patient (or parent/guardian if minor) Date