



Date: _____

Please print legibly.

Patient's Name:		Date of Birth:	Age:	Sex:
Address:		City:	State:	Zip:
Home Phone #:	Work Phone #:	Cell Phone #:	Email Address:	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Other	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	Primary Phone #: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
SSN#:	Referred By:			
Emergency Contact:		Phone #:		Relationship:
Patient Employer:			Phone #:	
Spouse's Employer:			Phone #:	
Primary Insurance:			Insurance #:	
Secondary Insurance:			Insurance #:	
Preferred Pharmacy:		Preferred Communication Method:		
		Phone Call: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Other: <input type="checkbox"/> Email <input type="checkbox"/> Text Message	

I certify that this information is true and complete to the best of my knowledge.

Patient's Signature

Preparer's Signature

Date