



PATIENT INFORMATION SHEET

PLEASE PRESENT UP-TO-DATE INSURANCE CARDS TO RECEPTIONIST

SOCIAL SECURITY #: _____ DATE OF BIRTH: ____/____/____ SEX: M F

PATIENT'S NAME: Last _____ First _____ MI _____

DO YOU HAVE A LIVING WILL? Y N

LOCAL ADDRESS: _____ City _____ State/Zip _____

LOCAL PHONE: (____) _____ OUT OF STATE PHONE: (____) _____

CELL PHONE: (____) _____ eMAIL ADDRESS _____

OUT OF STATE ADDRESS: _____ City _____ State/Zip _____

EMPLOYER: _____ EMPLOYER'S PHONE: _____

MARITAL STATUS: MARRIED SINGLE WIDOWED DIVORCED

SPOUSE'S NAME: Last _____ First _____ MI _____ DATE OF BIRTH: ____/____/____

SPOUSE'S SOCIAL SECURITY #: _____

SPOUSE'S EMPLOYER: _____ SPOUSE'S EMPLOYER'S PHONE: _____

NAME & PHONE NUMBER OF NEAREST RELATIVE NOT LIVING WITH YOU:

NAME: _____ PHONE NUMBER: _____

DUE TO NEW GOVERNMENT GUIDELINES, WE ARE NOW REQUIRED TO ASK THE FOLLOWING INFORMATION:

RACE:

- | | |
|--|---|
| <input type="checkbox"/> AMERICAN INDIAN OR ALASKAN NATIVE | <input type="checkbox"/> HISPANIC |
| <input type="checkbox"/> ASIAN | <input type="checkbox"/> OTHER RACE |
| <input type="checkbox"/> NATIVE HAWAIIAN | <input type="checkbox"/> OTHER PACIFIC ISLANDER |
| <input type="checkbox"/> BLACK OR AFRICAN AMERICAN | <input type="checkbox"/> UNREPORTED / REFUSED TO REPORT |
| <input type="checkbox"/> WHITE | |

ETHNICITY:

- HISPANIC
 NON-HISPANIC
 REFUSE TO REPORT

LANGUAGE:

- ENGLISH RUSSIAN
 OTHER SPANISH
 INDIAN (INCLUDES HINDI & TAMIL)

FAMILY PHYSICIAN'S NAME: _____ PHONE: _____

First Last

REFERRING PHYSICIAN'S NAME: _____ PHONE: _____

First Last

DOES YOUR DOCTOR NEED TO AUTHORIZE THIS VISIT FOR YOUR INSURANCE? Y N