Name:_____
Last First MI Prefers to be called/Nickname

Date of Birth:_____ Gender:_____

Mailing Address:_____

_____
CITY STATE ZIP

Primary Phone:_____ Secondary phone: _____

Work Phone:_____ Personal Email: _____

Marital Status: ☐ Single ☐ Life Partner ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Declined

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American ☐ White ☐ Declined

Religion: _____ ☐ Declined

Ethnicity: Do you consider yourself to Hispanic or Latino? ☐ Yes ☐ No ☐ Declined

Preferred Language: ☐ English ☐ Other (please specify):_____ _____

EMPLOYER:_____ Occupation:_____
Status: ☐ Part-time ☐ Full-time ☐ Self-employed ☐ Retired ☐ Active Military ☐ Disabled ☐ Student ☐ Unemployed

EMERGENCY CONTACT

Name:_____ Relation to Patient:_____
LAST FIRST

Home Phone:_____ Cell:_____

PARTY RESPONSIBLE FOR PAYMENT ☐ Check if same as patient

Name:_____ DOB:_____ _____

Address:_____

_____
CITY STATE ZIP

Home Phone:_____ Cell:_____ Relation:_____ _____

SIGNATURE_____ **DATE**_____
(Patient or Authorized Representative)

How did you hear about our practice?

☐ Referring Physician ☐ Online/Practice Website ☐ Family/Friend (Name)_____
☐ Insurance ☐ Newspaper ☐ Television ☐ Other_____