NAME: ______________________________ AGE: ____ BIRTH DATE: _______ SEX: □**MALE** / □**FEMALE**

ADDRESS: ____

CITY: ______________________________________ STATE: ___________ ZIP: _____________________

HOME PHONE: ________________ CELL PHONE: __________________ WORK PHONE: ______________

EMAIL ADDRESS: ____ SSN#: ______________________

PREFERRED COMMUNICATION: □EMAIL □HOME PHONE □CELL PHONE □WORK PHONE

EMPLOYMENT STATUS: ___________ EMPLOYER: ____

MARITAL STATUS :
□ SINGLE □ MARRIED □ DIVORCED □ WIDOWED □ LEGALLY SEPARATED □ DOMESTIC PARTNER

EMERGENCY CONTACT: __________________ PHONE: _____________ RELATIONSHIP: _____________

REFERRING PROVIDER: ____________________ PRIMARY CARE PROVIDER: ______________________

RACE: □ AMERICAN INDIAN OR ALASKAN NATIVE □ ASIAN □ BLACK OR AFRICAN AMERICAN
□ OTHER PACIFIC ISLANDER □ UNKNOWN/OTHER RACE □ WHITE OR CAUCASIAN

ETHNICITY: □ HISPANIC OR LATINO □ NON-HISPANIC OR LATINO □ UNKNOWN

RELIGION: _________________________ PREFERRED LANGUAGE: ____________________________

IF PATIENT IS A MINOR: PLEASE COMPLETE THIS SECTION
MOTHER'S NAME: _________________________ MOTHER'S DOB: ______ MOTHER'S PHONE: _______

FATHER'S NAME: _________________________ FATHER'S DOB: ______ FATHER'S PHONE: ________

IS MOTHER THE GUARANTOR? **YES / NO** IS FATHER THE GUARANTOR? **YES / NO**

PRIMARY INS MEMBER NUMBER/ID#_____________ GROUP #: ________ GROUP NAME: _____________

SUBSCRIBER NAME: ________________ SUBSCRIBER DOB: _____ RELATIONSHIP TO PATIENT: ________

SECONDARY INS MEMBER NUMBER/ID#_____________ GROUP #: ________ GROUP NAME: ___________

SUBSCRIBER NAME: ________________ SUBSCRIBER DOB: _____ RELATIONSHIP TO PATIENT: ________