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|  **PATIENT INFORMATION SHEET** |
| Patient Name (last, first, MI) | Date of Birth | Social Security Number |
| Mailing Address | Home Telephone | Work Telephone |
| City State Zip Code | Cell Phone | Marital Status |
| Primary Care Physician | Driver’s License Number |
| Patient’s Employer | Patient Employer’s Address |
| Emergency Contact: Name & Number | Relationship of Contact to You: |
|  |  |
| Spouse’s Name | Spouse’s Telephone  |
| Spouse’s Social Security Number | Spouse’s Date of Birth |
| **INSURANCE INFORMATION** |
| Primary Health Plan | Secondary Health Plan |
| Group # | ID# | Group # | ID# |
| Name of Policy Holder (last, first, MI) | Name of Policy Holder (last, first, MI) |
| Telephone Number | Date of Birth | Telephone Number | Date of Birth |
|  |
|  **Race**American IndianAfrican AmericanCaucasianOther: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  **Ethnicity**Hispanic or LatinoNot Hispanic or LatinoOther: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Preferred Pharmacy:  |
|   |
| Signature of Patient or Responsible Party(must be at least 18 years of age) | Date (Month/Day/Year) |