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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 Indian  African American  Caucasian  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Ethnicity**  Hispanic or Latino  Not Hispanic or Latino  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Preferred Pharmacy: | |
|  | |
| Signature of Patient or Responsible Party  (must be at least 18 years of age) | | Date (Month/Day/Year) | |