PATIENT'S INFORMATION

APPOINTMENT DATE_____

(*Confidential information for your file*)
PLEASE PRINT

NAME_____ SEX M F AGE_____ BIRTHDATE_____
First Middle Last

RACE_____ ETHNICITY: __Hispanic __Non-Hispanic PREFERRED LANGUAGE: _____

HOME ADDRESS_____
Street City State Zip

EMAIL_____ CELL PHONE_____ HOME PHONE_____

EMPLOYED BY_____ WORK PHONE_____

SPOUSE'S NAME_____ BIRTHDATE_____

ADDRESS_____ CELL PHONE_____ HOME PHONE_____

EMPLOYED BY_____ WORK PHONE_____

PERSONAL PHYSICIAN_____ ADDRESS_____ PHONE_____

REFERRAL SOURCE (How did you find out about us?) _____

PHARMACY NAME_____ STREET_____ CITY_____

PHARMACY PHONE NUMBER_____

EMERGENCY CONTACT_____

RELATIONSHIP_____ CELL PHONE_____ HOME PHONE_____

INSURANCE INFORMATION

#1 INSURANCE COMPANY NAME_____ PLAN NAME_____ GROUP #_____

IDENTIFICATION #_____ISSUE DATE_____ NAME OF POLICY HOLDER_____

PROVIDER PHONE NUMBER_____ CO-PAY AMOUNT $_____

#2 INSURANCE COMPANY NAME_____ PLAN NAME_____ GROUP #_____

IDENTIFICATION #_____ISSUE DATE_____ NAME OF POLICY HOLDER_____

PROVIDER PHONE NUMBER_____ CO-PAY AMOUNT $_____

TOBACCO USE

(Please circle one) Never Current Smoker Former Smoker Second-Hand Smoke Exposure

(Please circle one all that apply) Cigarettes Pipe Cigars Smokeless Tobacco

Smoked for how many years? _____ How many packs/day_____ Ready to quit? Yes No Quit date_____