PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. **Please print.** All information will be confidential.

Date: _____ Patient Name: _____
FIRST MI LAST

SSN: _____ ❑ Male ❑ Female Birth date: _____

Please fill in **all** the phone numbers below (***check the number we should call first***):

❑Home Phone:_____ ❑Cell Phone:_____ ❑Work Phone:_____

Email address: _____@_____

Address:_____ City:_____State:_____ ZIP:_____

Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Primary language spoken: ❑ English ❑ Spanish ❑ Other: _____

Race/Ethnicity: ❑ Caucasian ❑ African-American ❑ Hispanic ❑ Asian ❑ American Indian or Alaskan
❑ Native Hawaiian or other pacific islander ❑ Other race ❑ I refuse to report

You must provide us with the name and phone of a person to contact in case of an emergency. This must be another person and phone number (**not same number as above**) so that we can contact you even if you are out of town:

Contact Name:_____ Phone:_____
This contact is my : ❑ brother or sister ❑ child ❑ father or mother ❑ spouse ❑ _____
❑ I do not have or cannot provide an emergency contact

Who can we thank for referring you?_____

Do you have medical advance directives or power of attorney? ❑Yes (please leave us a copy) ❑No
If you do not have medical advance directives or power of attorney, would you like information? ❑Yes ❑No

Name of Local Pharmacy: _____ Address:_____City:_____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable directly to the doctor. In case of a medical emergency, if the patient is between 15-17 years old, I give you my permission to treat in my absence.

I also authorize the release of all medications prescribed electronically by my other doctors (this will help us prevent an interaction with medications that we prescribe for you).

_____ _____
Signature of patient or parent/guardian if minor Date