Name:
DOB:
Chart:
Age:
Date:

Welcome To Our Office

DATE: ____________________

PATIENT INFORMATION

PATIENT'S NAME (PLEASE PRINT)	GOES BY	SS#	MARITAL STATUS S / M / W / D / SEP	SEX M / F	AGE	BIRTH DATE
MAILING ADDRESS		CITY AND STATE	ZIP CODE	CELL PHONE# / HOME PHONE# / BUS PHONE#		
EMAIL						
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)					
SPOUSE OR PARENT'S NAME(INS)			SPOUSE'S DATE OF BIRTH(INS)			
IF STUDENT, COMPLETE THIS SECTION ☐ FULL TIME ☐ PART TIME	NAME OF SCHOOL					

PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY

HOW DID YOU HEAR ABOUT US:
- ☐ REFERRING DOCTOR____________________
- ☐ ATHLETIC TRAINER
- ☐ RELATIVE
- ☐ FRIEND____________________
- ☐ RADIO
- ☐ TELEVISION

WHO CAN WE RELEASE INFO OR DISCUSS CARE WITH:
1)
2)
3)

WHO IS YOUR PRIMARY CARE DOCTOR:

CHOOSE ONE UNDER EACH CATEGORY

RACE	ETHNICITY	PREFERRED LANGUAGE
☐ Asian	☐ Latino or Hispanic Identity	☐ English
☐ Native Hawaiian	☐ Non-Latino or Non-Hispanic Identity	☐ Spanish
☐ Other Pacific Islander	☐ Unknown	☐ German
☐ Black/African American	☐ Prefer Not to Report	☐ French
☐ American Indian/Alaska Native		☐ Italian
☐ White		☐ Chinese
☐ More than 1 Race		☐ Russian
☐ Other		☐ Other

PATIENT SIGNATURE ____________________ DATE ____________