

Name:  
 DOB:  
 Chart:  
 Age:  
 Date:



Welcome To Our Office

DATE: \_\_\_\_\_

**PATIENT INFORMATION**

PATIENT'S NAME (PLEASE PRINT)		GOES BY	SS#	MARITAL STATUS					SEX	AGE	BIRTH DATE	
				S	M	W	D	SEP	M	F		/ /
MAILING ADDRESS			CITY AND STATE			ZIP CODE		CELL PHONE#				
								HOME PHONE#				
EMAIL								BUS PHONE#				
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												
<input type="checkbox"/> FULL TIME		<input type="checkbox"/> PART TIME		NAME OF SCHOOL								

PRIMARY INSURANCE COMPANY						SECONDARY INSURANCE COMPANY					
HOW DID YOU HEAR ABOUT US:											
<input type="checkbox"/> REFERRING DOCTOR _____						<input type="checkbox"/> FRIEND _____					
<input type="checkbox"/> ATHLETIC TRAINER						<input type="checkbox"/> RADIO					
<input type="checkbox"/> RELATIVE						<input type="checkbox"/> TELEVISION					

WHO CAN WE RELEASE INFO OR DISCUSS CARE WITH:

1)

2)

3)

WHO IS YOUR PRIMARY CARE DOCTOR:

<b>CHOOSE ONE UNDER EACH CATEGORY</b>		
<b>RACE</b>	<b>ETHNICITY</b>	<b>PREFERRED LANGUAGE</b>
<input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> White <input type="checkbox"/> More than 1 Race <input type="checkbox"/> Other	<input type="checkbox"/> Latino or Hispanic Identity <input type="checkbox"/> Non-Latino or Non-Hispanic Identity <input type="checkbox"/> Unknown <input type="checkbox"/> Prefer Not to Report	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> German <input type="checkbox"/> French <input type="checkbox"/> Italian <input type="checkbox"/> Chinese <input type="checkbox"/> Russian <input type="checkbox"/> Other

\_\_\_\_\_  
 PATIENT SIGNATURE

\_\_\_\_\_  
 DATE