GENERAL INFORMATION

PLEASE FILL IN THE APPROPRIATE SPACES (All information is confidential):

CONTACT INFORMATION

Name _____

Name you go by _____

Address _____

City _____

State _____ Zip _____

Cell Phone _____

Primary insured _____

Home Phone _____

Address _____

Work Phone _____

Email _____

Relationship to insured _____

CMS REQUIRES PROVIDERS TO REPORT

Preferred language _____

Race Am. Indian or Alaskan Native / Asian
Native Hawaiian or Pacific Islander /
Black / White / Mixed race / Other
I decline to answer (Not gov't's business!)

Ethnicity Hispanic or Latino
Not Hispanic or Latino
I decline to answer (Not gov't's business!)

EMPLOYMENT INFORMATION

Occupation _____

Employer _____

INSURANCE INFORMATION

Ins. company _____

(If patient is the insured, answer *self* ; disregard the redundant questions)

Primary insured _____

Insured's address _____

_____

Insured's phone _____

Relationship to insured _____

Insured's birth date _____

Insured's employer _____

EMERGENCY CONTACT INFO.

Name _____

Phone _____

Relationship _____

SMOKING STATUS

Daily smoker / Current some day smoker / Former smoker / Never smoked

We will not contact you unless it is for purposes relative to your care; however, from time to time, we may need to confirm / alter appointments or disseminate educational materials. Please indicate any methods of communication you wish us to use & *circle* your *preferred* method? Thank you.

☐ **home phone** ☐ **work phone** ☐ **cell phone** ☐ **e-mail**