

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 _____

Home Phone _____

Work Phone _____

Email _____

Birth Date _____ Sex M / F

Marital Status S / M / D / W

Referred by sign / internet / friend / _____

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 _____

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!)

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