**Patient Information Sheet**

**PERSONAL INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Last Name** | **First Name** | **MI** | **Date of Birth** | **Age** |
| **Street Address/ P.O. Box** | **City** | **State** | **Zip Code** |
| **Social Security Number** | **Home Phone Number** (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ | **Cell Phone Number**(\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ |
| **Employer** (if applicable) | **Work Phone Number**(\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ |
| **Spouse Name** | **Spouse Contact Number**(\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Sex** Male  Female**Marital Status** Single Married Widowed Divorced | **Race** American Indian  Asian African American or Black  Native Hawaiian White  Multiracial**Ethnicity** Hispanic  Non-Hispanic |

|  |
| --- |
| **CONTACT INFORMATION** **(Outside of Household)** |
| Name |
| Relationship to Patient |
| Telephone NumberHome (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_Cell (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary Insurance** | **Policy Number** | **Subscriber** | **Relationship to Patient** Self Spouse DOB:\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_ |
| **Secondary Insurance** | **Policy Number** | **Subscriber** | **Relationship to Patient** Self Spouse DOB:\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_ |
| **Name of Primary Care Provider** | **Place of Practice** |

**LEGAL GUARDIANSHIP INFORMATION (If Applicable)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name** | **First Name** | **MI** | **Relationship to Patient** |
| **Street Address/ P.O. Box** | **City** | **State** | **Zip Code** |
| **Social Security Number** | **Home Phone Number** (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ | **Cell Phone Number**(\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ |

**See Reverse Side. Signature Required**

**Acknowledgement of Review of Notice of Privacy Practices**

I have reviewed the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient/Legal Guardian Date