**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 Number  Home (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_  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