Welcome to Our Office

Patient Information:

Title: Mr. Mrs. Ms. Dr. Other **Gender:** ☐ **Male** ☐ **Female**

First Name: **MI:** **Last Name:**

Address:

City: **State:** **Zip:** **Email Address:**

Home Phone: **Work Phone:** **Cell Phone:**

Date of Birth: **SSN:** **Marital Status:** ☐ Single ☐ Married ☐ Other

Employer: **Occupation:**

Insured's Full Name: **Insured's Date of Birth:**

Insured's Social Security #: **Relationship to Insured:**

In order for us to be **HIPAA compliant**, we must now request the following additional information for our records:

Please Check One in **EACH** Category::

Preferred Language: ☐ English ☐ Spanish

Race:
- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian
- ☐ Other Pacific Island
- ☐ Hispanic

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Preferred Method of Contact: ☐ Email ☐ Postal ☐ Telephone

Please list any medications you are taking:

Please list any allergies you have (medications and other):

Please name the pharmacy you use: