PATIENT INFORMATION FORM

NAME: ____ DATE: ______________

SS# ____________________ AGE: _____ DATE OF BIRTH: ___/___/_____

ADDRESS: ____ SEX: ____

____ MARITAL STATUS: ___
CITY STATE ZIP

PHONES: HOME: ________________ CELL: ______________

MAY WE LEAVE MESSAGES ON VOICE MAIL/ANS MACHINE: ___YES ___NO

LEAVE MESSAGE WITH FAMILY MEMBER: _____YES _____NO INITIAL: _____

APPOINTMENT REMINDER METHOD: TEXT__ PHONE__ EMAIL__

EMERGENCY CONTACT: ____________________________ PHONE: ____________
RELATIONSHIP: __________________________

E-MAIL ADDRESS: ________________________________

REASON FOR VISIT: ____

ALLERGIES: ____
DO YOU HAVE A LATEX ALLERGY? ______________

DO YOU HAVE SLEEP APNEA? ______YES _______NO

PRIMARY CARE PHYSICIAN: ____

INSURED'S NAME: ________________________________ DOB: ___/___/_____

PHARMACY NAME: ______________________________ ADDRESS: _________________________

MAIL ORDER PHARMACY: ____

INFORMATION REQUIRED TO BE COLLECTED BY GOVERNMENT:

RACE ______________ HISPANIC/LATINO ____ NON-HISPANIC/LATINO ____

PREFERRED LANGUAGE __________________________