

Patient	Responsible Party - if different than patient Patient Relationship <input type="checkbox"/> Child <input type="checkbox"/> Other _____
Today's Date ____ / ____ / 20 ____	Responsible Party Date of Birth ____ / ____ / ____
Social Security #	
Legal First Name, Middle	
Legal Last Name	

Mailing/Street Address	
Apt/Bldg/Suite#	
City, State, Zip Code	

Home Phone	()	()
Cell Phone	()	()
Work Phone	()	()
E-mail address		

Date of Birth	
Preferred Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> _____
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Race/Ethnicity	<input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> _____

	Primary Insurance - if applicable	Secondary Insurance - if applicable
Name of Insurance		
Primary Policyholder Name		
Date of Birth		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female

1. Emergency Contact _____ Phone () _____ Alt. Phone () _____

2. Reason for today's visit _____

3. Preferred Pharmacy and Location _____

4. Who is your Primary Care Physician (PCP) (Physician that provides annual physicals and preventive medicine screenings for you)?

n/a or Doctor Name and/or Practice Name _____

City _____ State _____ Phone # (if known) () _____

5. Would you like notes from today's visit forwarded to your Primary Care Physician (PCP)? yes no

6. If we are your primary care physician or you would like for us to be your primary care physician, please check here and we will direct your care towards annual physicals, labwork and preventive screenings in compliance with the American Medical Association guidelines.