Patient Information Sheet

Patient's Full Name: ____ Sex: M or F

Date of Birth: __________________________ Age: ______________ Date of last physical:_____________

Address:____ City: ___________________________

Zip: _______________County:__________________

Mother's Full Name: ________________________________Father's Full Name:____________________________

Mother's Primary #: ___________________________Cell: _____________________Work:_____________

Mother's Email: _____________________________________

Father's Primary #: ____________________________Cell: _____________________Work:_____________

Father's Email:________________________________

American born: yes or no Preferred Language: _________________

Optional

Race: ☐ American Indian or Alaskan Native
☐ Asian
☐ African American/Black
☐ Caucasian/White
☐ Native Hawaiian or other Pacific Islander

Ethnicity: ☐ Hispanic or Latino
☐ Non-Hispanic or Latino

Type of Medical Insurance Company: _____________________________________ PPO, POS, or HMO?

Address of Insurance (P.O. Box): _____________________________

Subscriber's Full Name: ______________________________Subscriber's Date of Birth:_______________

Insurance/Subscriber ID:_______________________ Group name:_____________ Group Number:___________

Co-pay:____________ Deductible:_________ Co-insurance:_____________

*Guarantor is the person financially responsible for the patient

Guarantor's Full Name: ______________________________Guarantor's Date of Birth:________________

Guarantor's SSN:_______________________

Guarantor's Employer:__________________ Employment Status: Full-Time or Part-Time

Work Phone Number: __________________Ext:_________ Fax:_____________________

Pharmacy Preference

Name: _________________________ Address:____________________________________Phone:_____________

Name: _________________________ Address:____________________________________ Phone:____________