

IMPORTANT NOTICE

Due to HIPAA requirements, this form must be filled out completely. Please ask for help if you have questions about any field. We will be unable to file insurance for incomplete forms. Thank You.

PATIENT INFORMATION

| | | | |
|---|---|--|---|
| Full Name: | | Social Security #: | |
| Date of Birth: | Name you wish to be called: | | |
| Legal Sex: <small>(as on your driver's license)</small> | Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Choose not to disclose | <input type="checkbox"/> Transgender Female <small>(male-to-female)</small> <input type="checkbox"/> Transgender Male <small>(female-to-male)</small> <input type="checkbox"/> Other | Sex at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Choose not to disclose |
| | | <input type="checkbox"/> Unknown <input type="checkbox"/> Uncertain <input type="checkbox"/> Not recorded on birth certificate | Sexual Orientation: <input type="checkbox"/> Straight <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Choose not to disclose |
| | | <input type="checkbox"/> Bisexual <input type="checkbox"/> Don't Know <input type="checkbox"/> Something else | |
| Mailing Address: | | | |
| City, State, Zip: | | County: | |
| Street Address: | | | |
| City, State, Zip: | | County: | |
| Home Phone #: | Work Phone #: | Mobile #: | |
| Email Address: | | I DON'T HAVE EMAIL NO THANKS | |
| Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Married <input type="checkbox"/> Significant Other <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Other <input type="checkbox"/> Unknown | Do you need an Interpreter? YES NO Language Preference: Written Language Preference: Religion: | Race: <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other, Pacific Islander <input type="checkbox"/> Black / African American <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Declined | Ethnicity: <input type="checkbox"/> Not Hispanic, Latino/a or Spanish origin <input type="checkbox"/> Colombian <input type="checkbox"/> Cuban <input type="checkbox"/> Guatemalan <input type="checkbox"/> Honduran <input type="checkbox"/> Mexican, Mexican American or Chicano/a <input type="checkbox"/> Other Hispanic, Latino/a or Spanish Origin <input type="checkbox"/> Peruvian <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Salvadoran <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Unknown |
| Primary Care Provider (PCP) Name: | | | |
| Emergency Contact Name and Relationship: | | | |
| Emergency Contact Phone #: | Is the Emergency Contact the Patient's Legal Guardian? YES NO | | |
| Employer Name: | | | |
| Employment Status: | <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed | <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Not Employed | Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time |
| <input type="checkbox"/> Active Military Duty <input type="checkbox"/> Other / Unknown | | | |

GUARANTOR INFORMATION

| | | | | | | |
|--|------|-------------------------------------|--------|--------|--------|-------|
| Who is financially responsible for this account? | SELF | EMPLOYER | SPOUSE | FATHER | MOTHER | OTHER |
| Primary Insurance Company: | | Secondary Insurance Company: | | | | |
| Subscriber Name: | | Subscriber Name: | | | | |
| Subscriber Social Security Number: | | Subscriber Social Security Number: | | | | |
| Subscriber Sex: | | Subscriber Sex: | | | | |
| Subscriber Date of Birth: | | Subscriber Date of Birth: | | | | |
| Subscriber Home Phone #: | | Subscriber Home Phone #: | | | | |
| Subscriber ID #: | | Subscriber ID #: | | | | |
| Subscriber Group #: | | Subscriber Group #: | | | | |

| | | | |
|--|------|-------|-------|
| What is your preference of contact for appointment reminders? | TEXT | EMAIL | PHONE |
| I authorize the following people access to my protected health or medical information (list name(s) and relationship(s) to patient): | | | |
| Do you have Advanced Directives? YES NO If yes choose type: ___ Health Care Power of Attorney/Living Will ___ DNR | | | |
| Preferred Pharmacy Name and Location: | | | |