Patient Information

Legal Name			Birthdate	
Street Address			Male ☐ Female ☐	Marital Sts
City	State	Zip	Social Security#	
1st.choice phone	Home ☐ Cell ☐		Occupation	
2nd.choice phone	Home ☐ Cell ☐		Employer	
Email Address			Employer phone#	

Responsible Party (Policy holder)/ Legal Guardian ***if minor, please have parent or legal guardian complete the following***

Legal Name			Birthdate
Street Address			Male ☐ Female ☐
City	State	Zip	Social Security#
1st.choice phone	Home ☐ Cell ☐		Occupation
2nd.choice phone	Home ☐ Cell ☐		Employer
Email Address			Employer phone#
Relationship to patient			Mother's Maiden Name:

As part of the American Recovery and reinvestment act, healthcare providers are required to obtain he following information. Please check the boxes that most apply to you.

Race (choose one)

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White/Caucasian
☐ Native Hawaiian or Other Pacific Islander ☐ More than one Race ☐ Other_____
☐ Unknown

Ethnicity (choose one)

☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Unknown

Emergency Contacts

Name	Contact Phone	Relation to patient
Name	Contact Phone	Relation to patient

Signature_____**Date**_____

(Patient or Responsible party/Guardian)