Patient Information

Date: _____

Last name _____ First name _____Middle _____

Address _____ PO Box _____ City/State _____ Zip _____

Date of birth ____/____/_____ Phone/home _____ cell _____ work _____

(**If a minor**) Parent/Guardian name _____ Date of birth ____/____/___

e-mail _____

Employer _____occupation _____

Insurance name _____ ID# _____

Subscriber name _____ Relationship _____Date of birth ___/____/___

Race: Caucasian / African-American / Hispanic / Asian Ethnicity: Hispanic / Non-Hispanic

Spoken language: English / Spanish / Sign language / Other (specify) _____

Single / Married / Divorced / Widowed / Civil Union

Members of your household : _____

Who should we notify in case of an emergency? _____ _____

Relationship to you: _____ phone _____

Your pharmacy: _____ location :_____

Do you have a living will? ☐ Yes ☐ No Would you like to discuss this? ☐ Yes ☐ No

Do you smoke? ☐ No ☐ Yes: How many per day? _____ Quit date _____

Do you drink alcohol? ☐ No ☐ Yes Beer / Wine How much per day/week? _____

Have you had:

☐ flu shot – date _____ ☐ pneumonia vaccine – date _____ ☐ tetanus shot – date _____

Females:

Date of last pap _____ last mammogram _____

How many pregnancies? _____ How many live births? _____ Cesareans? _____