PATIENT INFORMATION FORM

Please take a few minutes to complete this form. There may be times when it is urgent that we contact you, so please try to be as complete and accurate as possible, especially with phone numbers. Thank you very much. All information provided is completely confidential.

DATE TODAY ___________________________

LAST NAME ________________________________ FIRST NAME _____________________________ M.I. ____

PREFERRED FIRST NAME ____________________ DATE OF BIRTH ______________ SSN#______________

ADDRESS ____ (PO Boxes Not Allowed)

CITY____ STATE____________________ ZIP________________

HOME PH# _____________________ MOBILE PH# __________________ WORK PH#___________________

PREFERRED Ph# WEEKDAYS (**CIRCLE** ONE): **HOME** **MOBILE** **WORK**

EMAIL ____ PREFERRED CONTACT METHOD: ________________

MARITAL STATUS ______________________________ DRIV LIC. # _____________________________

Optional - We invite you to share your race, ethnicity, sexual orientation, and gender identity information:

RACE ______________________________________ ETHNICITY _______________________________________

SEX AT BIRTH ______________________________ SEXUAL ORIENTATION ____________________________

GENDER IDENTITY ___________________________ PRONOUN ___she/her ___they/them

Are you employed? _________ If yes, YOUR OCCUPATION ____

EMPLOYER NAME ____________________________________ PH.# _______________________________

ADDRESS ____

CITY____ STATE____________________ ZIP________________

(If you are married/committed, may we have your spouse/sig other information)

SPOUSE/SIG OTHER NAME _________________________ DATE OF BIRTH_____________________________

EMPLOYER_______________________________________ OCCUPATION _______________________________

MOBILE PH# _____________________________________ WORK PH#_________________________________

HOW DID YOU HEAR OF US? ____

WHO IS YOUR PCP (PRIMARY CARE PROVIDER)?____

PHARMACY NAME AND ADDRESS____

PHARMACY CITY,STATE,ZIP __________________________________ PH# ___________________________

EMERGENCY CONTACT NAME ______________________________________ RELN ____________________

MOBILE PH# _____________________________________ OTHER PH# _______________________________

Please sign below if you give us permission to message you (such as test results) via voice mail or e-mail:

SIGNED ____ DATE ____________________________________