

Today's Date \_\_\_\_\_

Please complete this form in order to ensure proper billing of your services. PLEASE PRINT

| Patient Demographic Information                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Name                                                                                                                                                                                                                                                              | Date of Birth:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Legal Name:                                                                                                                                                                                                                                                       | Sex assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Address:                                                                                                                                                                                                                                                          | Gender Identity:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Address:                                                                                                                                                                                                                                                          | Pronoun:<br><input type="checkbox"/> He/him/his <input type="checkbox"/> She/her/hers <input type="checkbox"/> They/them/theirs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| City: State: Zip:                                                                                                                                                                                                                                                 | Home Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Marital Status: Single Married Widowed<br>Separated Divorced Other                                                                                                                                                                                                | Cell Phone: Work Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                   | Email:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Preferred Language:                                                                                                                                                                                                                                               | Preferred Contact: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Email <input type="checkbox"/> MyChart                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Ethnicity:<br><input type="checkbox"/> Not Hispanic, Latino/a or Spanish origin<br><br><input type="checkbox"/> Hispanic, Latino/a or Spanish origin<br><br><input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Answer                           | Race: <i>(Response is not mandatory. Data is used for statistical reporting.)</i><br><b>Please choose all that apply.</b><br><input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic<br><br><input type="checkbox"/> Chinese American <input type="checkbox"/> Japanese American <input type="checkbox"/> Filipino American <input type="checkbox"/> Other Asian<br><br><input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Native Hawaiian<br><br><input type="checkbox"/> Decline to Answer <input type="checkbox"/> Unknown <input type="checkbox"/> Other |
| Primary Care Provider:                                                                                                                                                                                                                                            | Referring Provider:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Other Treating Providers (Name/Specialty):                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Are you visually impaired? <input type="checkbox"/> Yes <input type="checkbox"/> No    Are you hearing impaired? <input type="checkbox"/> Yes <input type="checkbox"/> No    Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Emergency Contact Information                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Name:                                                                                                                                                                                                                                                             | Relationship to Patient:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Address:                                                                                                                                                                                                                                                          | Home Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Address:                                                                                                                                                                                                                                                          | Work Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| City:                                                                                                                                                                                                                                                             | Cell Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| State: Zip:                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Guarantor Information</b> <i>Please complete if guarantor is other than self. The guarantor is the person financially responsible for this patient's bill.</i>                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Name:                                                                                                                                                                                                                                                             | Relationship to Patient:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Address:                                                                                                                                                                                                                                                          | Guarantor Date of Birth:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Address:                                                                                                                                                                                                                                                          | Home Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| City:                                                                                                                                                                                                                                                             | Work Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| State: Zip:                                                                                                                                                                                                                                                       | Cell Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Insurance Information</b> <i>*A separate form is required for Worker's Compensation, Automobile Liability, or Legal services.</i>                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Primary Carrier:                                                                                                                                                                                                                                                  | Subscriber Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Insurance Address:                                                                                                                                                                                                                                                | Relationship to Patient:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Telephone #:                                                                                                                                                                                                                                                      | Subscriber Date of Birth:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Effective Date:                                                                                                                                                                                                                                                   | Subscriber Employer:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| ID/Cert#:                                                                                                                                                                                                                                                         | Group Name/Plan:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Secondary Carrier:                                                                                                                                                                                                                                                | Subscriber Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Insurance Address:                                                                                                                                                                                                                                                | Relationship to Patient:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Telephone #:                                                                                                                                                                                                                                                      | Subscriber Date of Birth:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Effective Date:                                                                                                                                                                                                                                                   | Subscriber Employer:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| ID/Cert#:                                                                                                                                                                                                                                                         | Group Name/Plan:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Do you have a healthcare power of attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No    Do you have a living will? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| How did you hear of our practice?                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| *Is this visit a result of an accident (Auto/Worker's Comp/Personal Injury)? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Pharmacy Name:                                                                                                                                                                                                                                                    | City: Telephone#:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |