Additional Patient Information
*Please **CLEARLY** fill in the blanks*

- **Last Name:** ___________________ • **First Name:** ___________________ • **Middle initial:** ____
- **Name Prefix** (Circle one): Mr. | Mrs. | Miss | Other: ____ • **Name Suffix** (Jr., I, II, II, etc.): ____
- **D.O.B.** ____________ • **Sex:** ____ • **SSN:** ________________
- **Weight/Height:** _______ / ________ • **Marital Status:** _______________
- **Race** (*optional*): _______________ • **Ethnicity** (*optional*): _______________ • **Religion** (*optional*): _______________

- **Home Address:**

☐ Check this box if home & mailing address are the ***same***

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- **Mailing Address:**

☐ Check this box if home & mailing address are ***different***

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☐ **Home Phone #:** ____________________________

☐ **Cell phone #:** ____________________________

(Check box next to preferred contact # only)

- **E-mail address:** ____________________________

* By entering your email above, you are giving us permission to send newsletters containing helpful tips/information/discussions on wellness. You may unsubscribe at any time.

- **Advanced Directive** (if any): ____________________________
- **Emergency Contact:**

Name: ____________________________ Relationship to patient: ____________________________

Phone #: ____________________________ (Home / Cell) *circle one*

Address: ____

- **Next of Kin:**

Name: ____________________________ Relationship to patient: ____________________________

Phone #: ____________________________ (Home / Cell) *circle one*

Address: ____

- **Name of primary care physician/family physician:** _____________________________

PCP Address: ____

Phone #: ____________________________ Fax#: ____________________________

- **Pharmacy name:** ________________________________

Phone #: ___________________________________

Address: _______________________________________

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- By signing below, I acknowledge that it is my responsibility to inform the office of Dr. Hina Sidhu if any of the information I've provided above (e.g.: address, phone #, email, emergency contact, etc.) needs to be changed or updated:

Patient Name (printed): ____________________________

Patient Signature: ____________________________ **Date:** ___________________