CONFIDENTIAL PATIENT INFORMATION

Primary Physician: ____________________ Phone: _______________
Fax: _____________________

Last Name	First Name	MI	Birth Date	Today's Date	Patient Acct
Address		City	State	Zip Code	MRN
Home Phone: Work Phone:		Mobile Phone: Email:		Gender	Social Security #

Language:
Please select one:

- ☐ English ☐ Greek ☐ Vietnamese
- ☐ Spanish ☐ Italian ☐ Tagalog
- ☐ French ☐ Japanese ☐ Russian
- ☐ Arabic ☐ Korean ☐ Cambodian
- ☐ Chinese ☐ Mandarin ☐ Laotian
- ☐ German ☐ Persian ☐ Other

Race:
Please select one race that closely identifies you:

- ☐ Asian
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Declined to answer
- ☐ Unknown

Additional Race:
Please select one additional race that closely identifies you:

- ☐ Asian
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Declined to answer
- ☐ Unknown

Ethnicity
Hispanic or Latino- *A person of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture or origin regardless of race.* ***Please select:***

☐ Hispanic or Latino ☐ Non-Hispanic or Latino
☐ Decline to answer ☐ Unknown

Marital Status:

Employer:
Employer Address:

Emergency Contact	Home Phone	Work Phone	Relationship to Patient

I hereby give permission to __________________________________ my ___________________, **to receive all personal and confidential information regarding my health.** Phone Number (   ) _______-_________

Last Name	First Name	MI	Relationship to Patient	
Address		City	State	Zip Code
Home Phone: Work Phone:	Social Security #		Birth Date	Gender
Employer's Name	Employer's Address:			

PLEASE COMPLETE THIS SECTION IF PATIENT IS NOT THE **SPONSOR**/GUARANTOR

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance Name:		Insurance Name:	
Claims Address	CoPay	Claims Address	CoPay
City, State, Zip	Ins Ph. No.	City, State, Zip	Ins Ph. No.
Subscribers Name	Gender M ☐ F ☐	Subscribers Name	Gender M ☐ F ☐
Subscribers ID	Group No.	Subscribers ID	Group No.
Subscribers Birth Date	Effective Date	Subscribers Birth Date	Effective Date
Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐		Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐	

I authorize payment of my medical benefits be made directly to my physician for services rendered. I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information necessary related to my medical care and to facilitate payment of my medical expenses owed my physician.

_______________________________________ ____________________________________

SIGNED (Insured or Authorized) ***DATE***