

**Patient Information**

**Legal Patient Name:**

(First) (Middle) (Last)

**Preferred Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Maiden Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**

City State Zip

**Gender:** Male / Female

**Place of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State

**For Patients that Identify in the LGBT Community:**

**Gender Identity:**  Male, Female, Non-Binary

**Orientation:** L G B T

**Social Security Number**:

**Home Phone:** ( ) \_\_\_\_\_\_

**Is it ok to leave a message?** □ YES □ NO

**Mobile Phone:** ( ) \_\_\_\_\_\_

**Is it ok to leave a message?** □ YES □ NO

**Work Phone**: ­­­\_\_\_\_\_\_

**Is it ok to leave a message?** □ YES □ NO

**Which phone would you prefer to be contacted at?**

□ HOME □ CELL □ WORK

**Email Address**:

**Patient Demographics**

**Marital Status:** □ Married □Single

□Divorced □ Separated

□Widowed □Domestic Partner

**Race:** □ White □ Black or African America

□ Asian □ Native Hawaiian/ Other Pacific Islander □ Other

**Ethnicity:** □ Hispanic or Latino

□ Non-Hispanic or Latino

□ Declined to specify

**Language Preferred:** □ English □ Spanish □ Other

**Employee Status:** □ Full Time □ Part Time

□ Retired □ Other

\*If Working Full Time or Part Time:

Employer Name:

**Patient Referral Information**

□Self Referred (Please Check how you heard about us below)

□Friend/Family □Radio

□Newspaper Article □Airport Media

□Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Referring MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Current Physicians (This includes all current Specialists and/or Family Practice Physicians):

Name Specialty



**Responsible Party Information**

□ Responsible Party is same as Patient Information

\*Please fill out the following if information is different

than Patient Information

**Subscriber Name:**

First Last

**Subscriber Address:**

City State Zip

**Subscriber Date of Birth:** ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Subscriber Social Security #**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone:** ( )

**Mobile Phone**: ( )

**Work Phone:** ( )

**Patient Insurance Information**

\*Please provide insurance cards, photo ID and

prescription cards to the receptionist

**Primary Insurance:**

**Secondary Insurance**:

**Prescription Drug Plan:**

**Patient’s Preferred Pharmacy**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**:

City State Zip

**Pharmacy Phone**: ( )

**Medicare Required Questions**

\*Are you covered by Medicare? □ YES □ NO

(If **YES** please complete the following questions. If **NO** skip to next section.)

Are you or your spouse employed? □ YES □ NO

If yes, do you have group health coverage through an employer? □ YES □ NO

Are you entitled to Medicare because of Disability or End State Renal Disease? □ YES □ NO

Is this illness or injury the result of an automobile accident or other injury? □ YES □ NO

Is this illness or injury the result of an accident or illness that occurred at work? □ YES □ NO

Has treatment and payment been authorized by the Veteran’s Administration? □ YES □ NO

Are you entitled to any benefits under the Federal Black Lung Program? □ YES □ NO

**Acknowledgment**

To the best of my knowledge, all the information provided is true and accurate.

**Name of Patient: (Please Print)**

**Patient Signature:**

Date:\_\_\_\_\_\_\_\_\_\_\_

**Living Will/POA**

**Do you have a living will?** □ YES □ NO

**Do you have a Power of Attorney?** □ YES □ NO

**If yes who is your POA?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_