

IMPORTANT NOTICE

Due to HIPAA requirements, this form must be filled out completely. Please ask for help if you have questions about any field. We will be unable to file insurance for incomplete forms. Thank You.

PATIENT INFORMATION:

Full Name:			Social Security #:			
Date of Birth:			Name you wish to be called:			
Legal Sex: <small>(as on your driver's license)</small>	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Choose not to disclose	<input type="checkbox"/> Transgender Female <small>(male-to-female)</small> <input type="checkbox"/> Transgender Male <small>(female-to-male)</small> <input type="checkbox"/> Other	Sex at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Choose not to disclose	<input type="checkbox"/> Unknown <input type="checkbox"/> Uncertain <input type="checkbox"/> Not recorded on birth certificate	Sexual Orientation: <input type="checkbox"/> Straight <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Choose not to disclose	<input type="checkbox"/> Bisexual <input type="checkbox"/> Don't Know <input type="checkbox"/> Something else
Mailing Address:						
City, State, Zip:				County:		
Street Address:						
City, State, Zip:				County:		
Home Phone #:			Work Phone #:			
Email Address:	<input type="checkbox"/> I DON'T HAVE EMAIL <input type="checkbox"/> NO THANKS					

What is your preference of contact for appointment reminders? TEXT EMAIL PHONE

Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Married <input type="checkbox"/> Significant Other <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Other <input type="checkbox"/> Unknown	Do you need an Interpreter? YES NO	Race (choose one): <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Two or more races <input type="checkbox"/> Declined <input type="checkbox"/> Unknown	Ethnicity (where were you born?): <input type="checkbox"/> Not Hispanic, Latino/a or Spanish origin <input type="checkbox"/> Colombian <input type="checkbox"/> Cuban <input type="checkbox"/> Guatemalan <input type="checkbox"/> Honduran <input type="checkbox"/> Mexican, Mexican American or Chicano/a <input type="checkbox"/> Other Hispanic, Latino/a or Spanish Origin <input type="checkbox"/> Peruvian <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Salvadoran <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Unknown
Language Preference:		Written Language Preference:	
Religion:			

Primary Care Provider (PCP) Name: _____

EMERGENCY CONTACT & ACCESS TO INFORMATION / ADVANCE DIRECTIVES:

Emergency Contact Name and Relationship:			
Emergency Contact Phone #:			Is the Emergency Contact the Patient's Legal Guardian? YES NO
The following people may have access to my medical information (please list name(s) and relationship(s) to patient):			
Do you have any of the following: <input type="checkbox"/> Medical Power of Attorney <input type="checkbox"/> Living Will <input type="checkbox"/> DNR <input type="checkbox"/> GA Advance Directives			

GUARANTOR INFORMATION:

Who is financially responsible for this account?	SELF	EMPLOYER	SPOUSE	FATHER	MOTHER	OTHER
Employer Name:						
Employment Status:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed	<input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Not Employed	<input type="checkbox"/> Active Military Duty <input type="checkbox"/> Other / Unknown	Student Status:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	
Primary Insurance Company:			Secondary Insurance Company:			
Subscriber Name:			Subscriber Name:			
Subscriber Sex: M / F		Date of Birth:		Subscriber Sex: M / F		Date of Birth:
Subscriber Home Phone #:			Subscriber Home Phone #:			
Subscriber ID #:		Group #:		Subscriber ID #:		Group #: