PATIENT INFORMATION FORM
Please list all patients currently in our practice.

Date:_____

1. **Patient's Last Name:** **First:** **Middle Initial:** **DOB:** **Sex:** **Social Security#**

_____ _____ _____ _____ _____ _____

Race: ( ) Asian ( ) Black/African American ( ) White (origin of Europe, the Middle East, or North African)
( ) Hispanic/Latino ( ) American Indian/Alaska Native ( ) Native Hawaiian/Other Pacific Islander

Ethnicity: Hispanic ( ) Not Hispanic ( ) **Language:** English ( ) Spanish ( ) Other ( )_____

2. **Patient's Last Name:** **First:** **Middle Initial:** **DOB:** **Sex:** **Social Security#**

_____ _____ _____ _____ _____ _____

Race: ( ) Asian ( ) Black/African American ( ) White (origin of Europe, the Middle East, or North African)
( ) Hispanic/Latino ( ) American Indian/Alaska Native ( ) Native Hawaiian/Other Pacific Islander

Ethnicity: Hispanic ( ) Not Hispanic ( ) **Language:** English ( ) Spanish ( ) Other ( )_____

3. **Patient's Last Name:** **First:** **Middle Initial:** **DOB:** **Sex:** **Social Security#**

_____ _____ _____ _____ _____ _____

Race: ( ) Asian ( ) Black/African American ( ) White (origin of Europe, the Middle East, or North African)
( ) Hispanic/Latino ( ) American Indian/Alaska Native ( ) Native Hawaiian/Other Pacific Islander

Ethnicity: Hispanic ( ) Not Hispanic ( ) **Language:** English ( ) Spanish ( ) Other ( )_____

Primary Guardian's Name: _____ Relationship to Patient:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Social Security # _____ DOB: _____ Home Phone:(_____)_____ Cell:(_____)_____

Work:(_____)_____ Email:_____ Employment:_____

Other Guardian's Name: _____ Relationship to Patient:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Social Security # _____ DOB: _____ Home Phone:(_____)_____ Cell:(_____)_____

Work:(_____)_____ Email:_____ Employment:_____

Marital Status : Married___ Single___ Widowed___ Divorced___

Primary Insurance: _____ Insured Name:_____

Contract #_____ Group#_____ Effective Date: _____

Insurance Address:_____ Precert Phone: _____

Secondary Insurance: _____ Insured Name:_____

Contract #_____ Group#_____ Effective Date: _____

Insurance Address:_____ Precert Phone: _____

Nearest Relative: _____ Phone:_____

As per the Federal Register Volume.77, No.144 Healthcare Facilities are required to collect Race, Ethnicity, and Language in order to comply with meaningful use.

Updated 3/14/11