

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Legal Name \_\_\_\_\_ Sr. \_\_\_\_\_ Jr. \_\_\_\_\_ Sex \_\_\_\_\_

Mailing Address \_\_\_\_\_ Unit/Apt # \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Email Address \_\_\_\_\_

Social Security # \_\_\_\_\_ Ok to leave msg. on either phone? \_\_Y \_\_N

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Reminder preference: (Select only one) Phone \_\_\_\_\_ Text \_\_\_\_\_ Email \_\_\_\_\_

Race (select one or more):

- American Indian/AK-Native
- Asian
- White
- Black/African American
- Native Hawaiian/Other Pacific Islander
- Patient Declined
- Unknown (Unable to provide)

Primary Language:

- English
- Spanish
- French
- German
- Unknown (Unable to provide)
- Other

Ethnicity (select only1)

- Declined to Specify
- Hispanic or Latino
- Not Hispanic or Latino
- Unknown/Not Reported

Primary Care Physician (PCP) \_\_\_\_\_

**PARENT/ GUARDIAN IF PATIENT IS CHILD/SPOUSE**

Name - Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Relationship \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Mailing Address \_\_\_\_\_ Unit/Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Reminder preference: (Select only one) Phone \_\_\_\_\_ Text \_\_\_\_\_ Email \_\_\_\_\_

**EMERGENCY CONTACT OR 2nd Parent**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

**Insurance billing information for contracted carriers will be taken directly from your insurance card. Please present your card to the desk personnel once you have completed this form.**