**Patient Name** _____ [ ] M [ ] F **Birth date**: _____

**Preferred to be addressed as: _____

Address: _____City _____State _____ ZIP _____

**Email Address:** _____

**Home Phone**: _____ **Cell Phone:** _____

**Work Phone**: _____May we contact you at work? [ ] Yes [ ] No

Employer/School _____Occupation: _____

Social Security #: _____ Marital Status [ ] S [ ] M [ ] W [ ] D

**FOR MINORS ONLY:** Child lives [ ] with both parents [ ] with mother [ ] with father

Mother/Guardian: _____ Home Phone: _____ Cell Phone: _____

Father/Guardian: _____Home Phone: _____ Cell Phone: _____

**PRIMARY INSURANCE CO:** _____Subscriber Name: _____

Subscriber Social Security #: _____ Subscriber date of birth: _____

ID #: _____ Patient relationship to card holder: [ ] self [ ] spouse [ ] dependent

**SECONDARY INSURANCE CO:** _____ Subscriber Name:_____

Subscriber Social Security #: _____ Subscriber date of birth: _____

ID #: _____ Patient relationship to card holder: [ ] self [ ] spouse [ ] dependent

Who referred you to us? _____

**NAME OF PRIMARY CARE PHYSICIAN**: _____

May we update him/her on your medical care? [ ] Yes [ ] No

**May we leave normal test results on your answering machine/cell phone voice mail? [ ] yes [ ] no**

**EMERGENCY CONTACT**:

**Name :** _____**Relationship:** _____ **Phone #** _____

**May we speak with your EMERGENCY CONTACT regarding lab results, appointments or other medical information? [ ] Yes [ ] No**

**Patient (or parent of minor) signature** _____