PATIENT INFORMATION

NAME: ____

DATE OF BIRTH: ___________________ MARITAL STATUS: SINGLE / MARRIED / WIDOWED / DIVORCED

STREET ADDRESS: ____

CITY: _________________ STATE: _____________ ZIP CODE: ______________

PREFERRED PHONE NUMBER: ____________________________ (Circle: MOBILE/HOME)

SECONDARY PHONE NUMBER: ____________________________ (Circle: MOBILE/HOME)

IS IT OKAY TO LEAVE TEST RESULTS OVER VOICEMAIL? (Circle: YES/ NO)

NAMES OF INDIVIDUALS WE MAY DISCUSS SENSITIVE INFORMATION WITH: __________________________________

EMAIL: ____

PREFERRED METHOD OF COMMUNICATION: CIRCLE: PHONE / TEXT / EMAIL / PATIENT PORTAL

EMERGENCY CONTACT NAME: ________________ RELATIONSHIP: _______________PHONE:____________________

SECONDARY EMERGENCY CONTACT NAME: _______________RELATIONSHIP: __________ PHONE: _________________

PREFFERED LANGUAGE: ____________________ SECONDARY LANGUAGE: __________________________

EMPLOYER: ____

ETHNICITY: (Circle) HISPANIC/LATINA OR NOT HISPANIC/ LATINA

RACE: (Circle) AMERICAN INDIAN / ASIAN / AFRICAN AMERICAN / NATIVE HAWAIIAN / WHITE / OTHER

PREFERRED PHARMACY

PHARMACY NAME: ____________________________________ PHONE NUMBER:__________________

STREET/CITY: ____

PRIMARY CARE PHYSICIAN

NAME: ____M.D/D.O. PHONE: _____________________

STREET ADDRESS: ___________________________________ CITY/STATE/ZIP:__________________________