PATIENT INFORMATION FORM

Please take a few minutes to complete this form. There may be times when it is urgent that we contact you, so please try to be as complete and accurate as possible, especially with phone numbers. Thank you very much. All information provided is completely confidential.

DATE TODAY _____ [Office use: (HH Med Rec # _____]

PATIENT LAST NAME _____ FIRST NAME_____ M.I. _____

PREFERRED NAME _____ MAIDEN NAME_____

DATE OF BIRTH _____ SSN# _____ RACE _____

MARITAL STATUS M S D W _____ DRIV LIC. # _____ RELIGION _____

ETHNICITY (H, NH or D) _____ (H - Hispanic, NH - Non-Hispanic or D- Declined)

ADDRESS _____ (PO Boxes Not Allowed)

ZIP _____ CITY _____ STATE_____

HOME PH.# _____ WORK PH.# _____ CELL PH.# _____

FAX # _____ email: _____

PREFERRED PHONE NUMBER M-F 9-5 (**circle** one): **HOME** **WORK** **CELL**

Are you employed? _____ If yes, EMPLOYER NAME _____

EMPLOYER PH. # _____ FAX # _____

ADDRESS _____

ZIP _____ CITY _____ STATE_____

YOUR OCCUPATION _____

(If you are married, we need your spouse's information, please)

SPOUSE/SIG OTHER NAME _____ DATE OF BIRTH _____

EMPLOYER _____ OCCUPATION _____

(if different) HOME PHONE _____ WORK PHONE _____

HOW DID YOU HEAR OF US? _____

PHARMACY INFORMATION

PHARMACY NAME: _____

PHARMACY STREET ADDRESS: _____

PHARMACY CITY,STATE,ZIP _____ PHONE _____

Do we have permission to import your medication history using our electronic prescription software? YES NO

EMERGENCY CONTACT INFORMATION (not your spouse/sig other)

CONTACT NAME _____ RELATIONSHIP _____

HOME PHONE _____ WORK PHONE _____

PERMISSION TO LEAVE DETAILED MESSAGES ON YOUR VOICE MAIL or e-MAIL?

Please sign below if you give us permission to leave messages (such as test results) on your voice mail or e-mail:

SIGNED _____ DATE _____