Medical History Form

Referring Provider_____How did you hear about us?_____

First Name_____Middle_____Last_____
Address_____

Suffix_____Date of Birth_____Social Security_____-____-_____Gender: M / F

Primary Phone #_____Work Phone #_____E-mail_____

Emergency Contact Name:_____Phone Number:_____

Emergency Contact Relationship_____

Marital Status: Single Married Divorced Separated Widow Civil Union Domestic Partner

Race: American Indian or Alaska Native Asian Black or African American White
Native Hawaiian or other Pacific Islander Declined to specify

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to Specify

Preferred Language: English Spanish Declined to Specify

Preferred Contact Method: No Preference Email Phone Postal Patient Portal

Appt. Notification Contact Method: No Preference Email Phone Postal Patient Portal

Employer:_____Occupation_____
Employment Status: Full-time Part-time

Pharmacy _____Phone Number:_____

Guarantor ID: (Responsible for Bill)_____
Patient's Relationship to Guarantor:_____
Guarantor Name:_____Date of Birth_____
Guarantor Social Security_____-____-_____Guarantor Employer_____
Guarantor Primary Phone_____Work Phone:_____
Guarantor Employer_____
Insurance or Self-Pay
Primary Insurance Name_____PolicyNumber_____
Group Number_____
Patient's Relationship to Insured: (Self, Dependent, Spouse) Insured Date of Birth_____
Secondary Insurance Name and Policy Number_____
Tertiary Insurance Name and Policy Number_____