# PATIENT DATA SHEET

**First:** **MI:** **Last:**

**Date of Birth:** Age: Gender: Male ☐ Female ☐

**Mailing Address:**

**Physical Address:**

| **OK To Call** | **Phone:** | **Best Time To Call** |
|---|---|---|
| ☐ | Home: | |
| ☐ | Work: | |
| ☐ | Cell: | |

**SSN:**

**Height:** **Weight:**

**Race:**

☐ **American Indian / Alaska Native** ☐ **Asian** ☐ **Black or African American**
☐ **Native Hawaiian / Other Pacific Islander** ☐ **White** ☐ **Chose not to respond**

**Ethnicity:**

☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** ☐ **Chose not to respond**

**Preferred language:** ENG English
**Intepreter required?** ☐

☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Separated** ☐ **Unknown**

**Student Status:** ☐ **Full-Time** ☐ **Part-Time** ☐ **None**

**Provider:** **Phone:**
**Billing Ref:** **Phone:**

## EMPLOYMENT STATUS

Employment Status:
☐ **Active Military** ☐ **Full-Time** ☐ **None** ☐ **Part-Time** ☐ **Retired** ☐ **Self Employed**

| | |
|---|---|
| Employer: | Occupation: |
| Address: | |
| | |
| Phone: | |
| | |
| Employer: | Occupation: |
| Address: | |
| | |
| Phone: | |

## INSURANCE INFORMATION

| | |
|---|---|
| Primary Insurance | |
| Policy Holder's Name: | Holder's Birth Date: |
| Policy or Certificate #: | Group #: |
| Policy Holder's Employer: | |
| Secondary Insurance: | |
| Policy Holder's Name: | Holder's Birth Date: |
| Policy or Certificate #: | Group #: |
| Policy Holder's Employer: | |

*Please Note:* We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement regarding a disputed claim. Payment for the office charge is expected at the time services are rendered.

**Note: Please provide us with the most updated information down below.**

## CONTACTS

| Name | Phone | Work | Cell | Fax | Type |
| --- | --- | --- | --- | --- | --- |

## ALLERGIES

| Date | Status | Type | Allergen | Severity | Reaction | Source |
| --- | --- | --- | --- | --- | --- | --- |

## MEDICATIONS

| Medication | Dose | Dose Unit | Freq | Admin |
| --- | --- | --- | --- | --- |

## How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email
- ☐ Marketing Ad - Facebook
- ☐ Marketing Ad - Other ____________

**Specify if other :** ____________________

**Email:** ____________________

**Would you like to be contacted by email?** ☐ Yes ☒ No

____________________

**Signature of Patient**

____________

**Date**