



PATIENT INFORMATION SHEET

Patient/client:

Last name: _____ First: _____ Middle: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Date of birth: _____ Soc. Sec. # _____ Age: _____
 Sex: Male Female Marital status: Single Married Sep Div Widowed Other
Check the box next to number(s) where we may leave message(s) for you:
 Home phone: _____ Work phone: _____
 Cell phone: _____ Other phone: _____
 Email address: _____ Pager: _____
 Employment status: Full-time Part-time Unemployed Disabled
 Employer: _____
 Student status: Non-student Full-time student Part-time student
 School: _____ Grade: _____
 Pharmacy: _____ Location: _____ Phone # _____
 Referred by: _____

Person responsible for payment (Guarantor):

Last name: _____ First: _____ Middle: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Date of birth: _____ Soc. Sec. # _____ Age: _____
 Sex: Male Female Marital status: Single Married Sep Div Widowed Other
 Home phone: _____ Work phone: _____
 Cell phone: _____ Other phone: _____
 Email address: _____ Pager: _____
 Employment status: Full-time Part-time Unemployed Disabled
 Employer: _____
 Student status: Non-student Full-time student Part-time student

Next of kin:

Name: _____
 Address: _____

 Tel. # _____
 Relationship to patient: _____

Person to notify in case of emergency:

Name: _____
 Address: _____

 Tel. # _____
 Relationship to patient: _____

Primary Insurance:

Name of insurance: _____
 Policy # _____ Group # _____
 Subscriber name: _____ Subscriber ID # _____
 Plan type: HMO PPO POS Traditional

Secondary Insurance:

Name of insurance: _____
 Policy # _____ Group # _____
 Subscriber name: _____ Subscriber ID # _____
 Plan type: HMO PPO POS Traditional

I certify that the above information is complete and accurate.

 Patient or Parent/guardian

 Date