Patient Profile

DOS: **Doctor you are seeing today:**

Account number		SSN	
Patient Name		DOB	
Address		City/State/Zip Code	
Home Phone		Cell Phone	
Work Phone		E Mail Address	
Marital Status		Gender	
Employer		Employer Address	
Referring Dr.	Dr.	Referring Phone	
PCP Name	Dr.	PCP Phone	
Pharmacy Name		Pharmacy Phone	

Preferred Language: _____ **Interpreter Needed:** Yes: __ No: __

Ethnicity: Hispanic: __ Not Hispanic: __

Race: Asian __ Black or African American __ Hispanic __ White __ Native Hawaiian or other Pacific Islander __ Other __

Are you currently living at any of the following facilities? *If YES, please choose one.*

Skilled Nursing: ___ Hospice: ___ Rehab Facility: ___ Other: ___

Do you have an Advanced Will Directive, Living Will, Living Trust, or Power of Attorney? Yes: ___ No: ___

Emergency Contact Information
Name: Phone: Relationship:

Primary Insurance Information
Name: Subscriber Name:
Subscriber number: Subscriber DOB:
Relationship to Patient:
Subscriber Employer: _____ Subscriber SSN: _____

Secondary Insurance Information
Name: Subscriber Name:
Subscriber Number: Subscriber DOB:
Relationship to patient:
Subscriber Employer: _____ Subscriber SSN: _____

The "Institution providing this form" will file your insurance or collect self pay accounts. You, the patient will be responsible for any personal balances. Any account turned to an outside collection agency will accrue additional fees on the unpaid balance including any attorney/court cost in collecting that balance.

_____ _____

Patient Signature *Date*