Document # DMG1015 Acct #:_____

Patient Information: **Date:**_____

Patient name:_____ DOB:_____

SSN:_____ ☐ Male ☐ Female

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Communication preference: ☐ Home ☐ Cell ☐ Work

SMS texting for appointment confirmation: ☐ Yes ☐ No

Email:_____

Relationship Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Preferred Pharmacy:_____ Location:_____

Race: ☐ White/Caucasian ☐ African American ☐ American Indian ☐ Asian

☐ Pacific Islander ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline

Language: ☐ English ☐ Spanish ☐ Other ☐ Decline

Smoking Status: ☐ Never ☐ Current every day ☐ Current some days ☐ Former

☐ Heavy tobacco smoker ☐ Light tobacco smoker ☐ Decline

Emergency Contact:_____ Phone:_____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Other

Insurance Information:

Insurance Company:_____ ID #:_____

Guarantor/Insurance Policy Holder Name:_____ DOB:_____

Address:_____ SSN:_____

City:_____ State:_____ Zip:_____

I certify that the all the above information is correct and up to date.

Printed Name:_____ **Signature**:_____