Patient name: ____________________________ Date of birth: ____________________________

Primary Language: ________________________ Mothers Maiden Name: ____________________

Gender at birth: **M** __________ **F** __________

Gender Identity: **M** ________ **F** ______ **Nonbinary** _________ **X** ________

Race: *Please circle* **White/Caucasian** **African American** **Asian**

American Indian/Alaska Native **Hispanic** **Native Hawaiian/ Pacific Islander** **Other:** ____________________

Ethnicity: **Hispanic/Latino** **Not Hispanic/Latino** **Declined to specify/Unknown**

Patient address: ____

City: ____ Zip: ____________________________

Contact Information

Primary Contact: ________________________

Relationship to patient: __________________

Date of Birth: ____________________________

Work Phone: _____________________________

Cell Phone: ______________________________

Address: ________________________________

City: ____________________________________

State: ______________ Zip: _________________

Email: __________________________________

☐ I agree to receive email and/or text notifications for upcoming appointments.

Secondary Contact: ____________________

Relationship to patient: __________________

Date of Birth: ____________________________

Work Phone: _____________________________

Cell Phone: ______________________________

Address: ________________________________

City: ____________________________________

State: ______________ Zip: _________________

Email: __________________________________

☐ I agree to receive email and/or text notifications for upcoming appointments.

Parents/ Legal Guardians: Married Living together Single Separated Divorced

Please note, legal documentation is required for any custody arrangement

If not primary/secondary contact, please complete the information below:

Fathers Name: ____

Date of Birth: __________________________________ Work Phone: ________________________

Cell Phone: _________________________

Address: _______________________________________

City: ______________________________ State: ___________ Zip:____________________

Email:____

☐ I agree to receive email and/or text notifications for upcoming appointments.

Mothers Name: _________________________________

Date of Birth: __________________________________ Work Phone: __________________

Cell Phone: _________________________

Address: _______________________________________

City: ______________________________ State: ___________ Zip:____________________

Email:____

☐ I agree to receive email and/or text notifications for upcoming appointments.

Insurance Information:

Insurance Company: ____

Subscriber Name:____ **DOB:**__________________

Subscriber ID:____

Secondary Insurance: If Applicable

Insurance Company: ____

Subscriber Name:____ **DOB:**__________________

Subscriber ID:____

Family Medical History

Please check the boxes of relatives who have had any of the following:

	Mother	Father	Other Family Member *Please specify
Allergies			
ADHD			
Anxiety			
Asthma/Breathing problems			
Bleeding/Clotting disorders			
Cancer *type			
Depression			
Diabetes			
Digestive Issues			
Heart Disease			
High Cholesterol/ Blood Pressure			
Thyroid problems			
Other: *please specify			