

## GENERAL INFORMATION

PLEASE FILL IN THE APPROPRIATE SPACES (All information is confidential):

### CONTACT INFORMATION

Name \_\_\_\_\_

Name you go by \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Email \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex M / F

Marital Status S / M / D / W

Referred by sign / internet / friend / \_\_\_\_\_

### EMPLOYMENT INFORMATION

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

### INSURANCE INFORMATION

Ins. company \_\_\_\_\_  
(If patient is the insured, answer self; disregard the redundant questions)

Primary insured \_\_\_\_\_

Insured's address \_\_\_\_\_

Insured's phone \_\_\_\_\_

Relationship to insured \_\_\_\_\_

Insured's birth date \_\_\_\_\_

Insured's employer \_\_\_\_\_

### CMS REQUIRES PROVIDERS TO REPORT

Preferred language \_\_\_\_\_

**Race** Am. Indian or Alaskan Native / Asian  
Native Hawaiian or Pacific Islander /  
Black / White / Mixed race / Other  
I decline to answer (Not gov't's business!)

**Ethnicity** Hispanic or Latino  
Not Hispanic or Latino  
I decline to answer (Not gov't's business!)

### EMERGENCY CONTACT INFO.

Name \_\_\_\_\_

Phone \_\_\_\_\_

Relationship \_\_\_\_\_

### SMOKING STATUS

*Daily smoker / Current some day smoker /  
Former smoker / Never smoked*

We will not contact you unless it is for purposes relative to your care; however, from time to time, we may need to confirm / alter appointments or disseminate educational materials. Please indicate any methods of communication you wish us to use & *circle* your preferred method? Thank you.

☐ home phone

☐ work phone

☐ cell phone

☐ e-mail