

**Patient Information**

Name \_\_\_\_\_ Social Security# \_\_\_\_\_

Birthdate \_\_\_\_\_ Nickname \_\_\_\_\_ Marital Status \_\_\_\_\_ Gender \_\_\_\_\_

Mailing Address \_\_\_\_\_ Town \_\_\_\_\_ Zip \_\_\_\_\_

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

Contact Method (please circle preferred):      Primary Phone      Cell Phone      email

Employment Status (circle): Employed   FT Student   PT Student   Self-Employed   Retired   Other

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

Name of Closest Relation(for emergencies) \_\_\_\_\_ Relative's Phone \_\_\_\_\_

Please Circle One: Work Related?   Yes   No      Auto Accident?      Yes   No

Race (circle one): White   Asian   Japanese   Black/African American   Asian Indian   Korean

Hispanic   Chinese   Vietnamese   American Indian/Alaskan Native   Filipino   Native Hawaiian

Samoa   Guamanian or Chamorro   Other \_\_\_\_\_   I choose not to specify

Multi-Racial: Yes No Unknown

Ethnicity: Hispanic/Latino Not Hispanic/Latino I choose not to specify

Preferred Language: English   Spanish   American Sign Language   Chinese   French   German

Tagalog   Vietnamese   Italian   Korean   Russian   Polish   Arabic   Portuguese   Japanese

French Creole   Greek   Hindi   Persian   Urdu   Gujarati   Armenian   I choose not to specify

Verification Question (choose one by circling, then give a six character answer):

What is the name of your favorite pet?   In what city where you born?

What high school did you attend?   What is your mother's maiden name?

On what street did you grow up?   What was the make of your first car?

Verification Answer \_\_\_\_\_

Do you currently smoke tobacco of any kind?

Current every day smoker   Current sometimes smoker   Former smoker   Never been a smoker