Adult Patient Information

Patient

Primary Care Physician: ______________________________

Last Name: ____________________ First: ____________________ Mid: __________

DOB: ___ /___ /______ Sex: Male/Female SSN: ______-_____-________ Email: ____________________

Address: ______________________________ Primary Phone: ❒ Home ❒ Cell

Home Phone: (____)______ - _________

City:____________________ State: ______ Zip: __________ Cell Phone: (____)______ - _________

Employer: ______________________________ ❒ Full time ❒ Part time

Address: ______________________________

Spouse/Parents

Last Name: ____________________ First: ____________________ Mid: __________

DOB: ___ /___ /______ Sex: Male/Female SSN: ______-_____-________ Email: ____________________

Address: ______________________________ Primary Phone: ❒ Home ❒ Cell

City:____________________ State: ______ Zip: __________ Home Phone: (____)______ - _________

Cell Phone: (____)______ - _________

Employer: ______________________________ Ok to leave message: (Y / N)

Address: ______________________________ Work Phone: (____)______ - _________

City:____________________ State: ______ Zip: __________

Emergency Contact

Relation: ____________________

Last Name: ____________________ First: ____________________ Mid: __________

Address: ______________________________ Home Phone: (____)______ - _________

City:____________________ State: ______ Zip: __________ Cell Phone: (____)______ - _________

Patient

Race: ❒American Indian/Alaska Native ❒Asian ❒Black or African American ❒Hispanic ❒White ❒Other

Ethnicity: ❒Non-Hispanic ❒Hispanic/Latino ❒Refused to report

Preferred Language for healthcare discussion: ❒English ❒Spanish ❒Other____________________

(continued on back)

Insurance Information (Primary)

Insured's Last Name: ______________________________ First: ______________________________ MI: _____

Relationship to Patient:____________________________ DOB: ___ /___ /______ SSN:_____-____-_______

Insured Address:____ Phone: (____)______ - _________

City:_____________________________ State: ______ Zip: _______________

Insurance Name:____ Effective Date: ___ /___ /______

Employer Name:____

Insurance Information (Secondary)

Insured's Last Name: ______________________________ First: ______________________________ MI: _____

Relationship to Patient:____________________________ DOB: ___ /___ /______ SSN:_____-____-_______

Insured Address:____ Phone: (____)______ - _________

City:_____________________________ State: ______ Zip: _______________

Insurance Name:____ Effective Date: ___ /___ /______

Employer Name:____

Pharmacy

1) Name: ____ Phone: (____)______ - _________

Address: ____

2) Name: ____ Phone: (____)______ - _________

Address: ____

Preferred Communications

Phone call: ❒

Preferred Phone: (____)______ - __________

Preferred Language: ❒ English ❒ Spanish

Preferred Time to Call: ❒ Morning ❒ Afternoon ❒ Evening

Send Reminder/Follow-up Letters: ❒

Send Reminder/Follow-up Emails: ❒

Type of Reminders/Follow-up:

- Select All ❒
- Appointments ❒
- Lab results ❒
- Health Maintenance ❒
- Rx Confirmation ❒
- General Notification ❒

I give consent for ETCH to exchange information with the individuals listed on this form.

____ ______________________

Patient Signature **Date:**