## 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 _____

***EMPLOYMENT INFORMATION***

Occupation _____

Employer _____

***INSURANCE INFORMATION***

Ins. company _____

**(If patient is the insured, answer *self* ; disregard the redundant questions)**

Primary insured _____

Address _____

Phone _____

Relationship to insured _____

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 / Occasional 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**