Patient Information

Patient Name: ______________________________

Address: ______________________________

City: ____________ **State:** ____________ **Zip:** ____________

Home Phone: ____________ **Cell Phone:** ____________

Email: ______________________________

SS#: ____________ **DOB:** ____________

(Please circle)

Patient's Preferred Language: English Spanish Other: ____________

Ethnicity: Non-Hispanic Hispanic

Race: African American Asian Caucasian Hispanic Other: ____________

Medical Question:

Has the student had a wellness visit in the past 2 years? Y or N

If, Yes (Physician) ______________________________

Is the student currently on medication? Y or N

Does the student have a chronic illness that is being managed by a physician? Y or N

Insurance Information

Please send a copy of the insurance card or cards in with this form. Copy of driver's ID

Insurance Company: ______________________________

Name of Insured: ____________ **Insured's date of birth:** ____________

Relationship to patient: ______________________________

Employer: ____________ **Phone:** ____________

Billing Information – (who is responsible)

Name: ____________ **DOB:** ____________

Address: ______________________________

City: ____________ **State:** ____________ **Zip:** ____________

Home Phone: ____________ **Cell Phone:** ____________

Relationship to Patient: ______________________________

Employer: ______________________________