Account # ______________________

Date: ____________________

Application For Care

Patient Questionnaire

(The answers below will be part of your electronic file and are required by the US Government)

Legal Name: First____________________________Middle________________Last___________________________

Date of Birth_____________________ Social Security No. _______-_______-_______

Preferred method of contact **(for private messages)**: ☐ E-mail ☐ Home Phone ☐ Mail ☐ Cell Phone

Home Phone_________________ Cell____________________ E-mail______________________________________

Address: Street____

City____State_________________________Zip__________________

Marital Status: ☐ Married, Name of Spouse________________________ ☐ Single ☐ Divorced ☐ Separated

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Trans Man/Female-to-Male ☐ Transgender Female/Trans Woman/Male-to-Female ☐ Genderqueer, neither exclusively Male nor Female ☐ Additional gender category or other (please specify) ☐ Decline to specify

Sexual orientation: ☐ Straight or heterosexual ☐ Lesbian, gay, or homosexual ☐ Bisexual ☐ Something else, please describe ___________________________________ ☐ Decline to specify ☐ Don't know

Ethnicity/Race: ☐ White or Caucasian ☐ Hispanic or Latino ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American ☐ Asian ☐ Other______________________________________

Preferred Language: ☐ English ☐ Spanish ☐ German ☐ Other____

Family Doctor_________________________________ Referral Doctor_____________________________________

Insurance

☐ Self Pay ☐ Medicare/MediGold ☐General Insurance ☐ Workers Comp. ☐ Personal Injury

Insurance Company____ Group_______________________________

ID Number____ Are you the primary card holder? ☐ Yes ☐ No

Insured Name:____ Date of birth_____________________________

Secondary insurance: ☐ Yes ☐ No Name____