**CONFIDENTIAL PATIENT INFORMATION**

Today’s Date:

Name: / /

(Last) (First) (Date of birth)

Preferred Pronouns: (e.g. he/him, she/her, they/theirs, etc.):

Gender Identity: (e.g. Female, Male, Transgender Woman, Genderqueer, etc.):

Gender Expression: (Feminine, Androgynous, Masculine, etc.):

Assigned Sex at Birth:

Sexual Orientation (e.g. Lesbian, Gay, Heterosexual, Bisexual, Queer, Asexual, etc.):

Please specify any other considerations of inclusion:

Address:

Phone:

Phone Work:

Email Address:

Please circle preferred communication (phone, e-mail)

Is it okay to leave a message about your health? Yes / No

Do want to opt out of electronic communications about appointments, forms, etc? Yes / No

How did you hear of us?

Yellow Pages: Newspaper: Radio/TV: Internet: Sign:

Other:

Were you referred by another physician: 🞐 Yes 🞐 No

Referring Physician’s Name: Phone:

Address, City, State, Zip:

Who is your current Physician: Phone:

Employer: Occupation: Phone:

Address:

Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)

Name of Spouse (or parent for minor child):

Emergency Contact: Relationship to you: Phone:

Insurance Company: Phone:

Name of Insured: Relationship to the Insured:

Policy #: Group #:

*I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.*

***Clinic Policy requires payment at time of services.***

**Patient’s Signature Parent or Guardian’s Signature Date**

**Please Print Name Please Print Name**