



Patient Demographics

Patient's Legal Name:				Female ()
Last:	First:	Middle Initial:		Male ()
Mailing Address:		City:	State:	Zip:
Street Address:		City:	State:	Zip:
Home Phone (include area code) ()	Current Marital Status (Circle One) Single Married Divorce Widowed			Living Will? Yes () No ()
Cell Phone (include area code) ()	Email Address:			
Patient Date of Birth:	Patient Social Security Number:	Primary Care Provider:		
Patient Employer:		Patient Work Phone (include area code) ()		
Spouse's Name:	Spouse's Date of Birth:	Spouse's SSN (if Insured through Spouse):		
Emergency Notification (Not Living in Same Household) Name:		Emergency Notification Phone (include area code) ()		

**** RESPONSIBLE PARTY INFORMATION (Complete only if patient is a minor) ****

Responsible Party Relationship to Patient:	Responsible Party Home Phone (include area code) ()		
Social Security Number:	Date of Birth:		
Mailing Address:	City:	State:	Zip:
Street Address:	City:	State:	Zip:
Race: () White () American Indian or Alaskan Native () Native Hawaiian or other Pacific Islander () Asian () Black or African American () Declined Ethnicity: () Hispanic or Latino () Not Hispanic or Latino () Declined Language: () English () Spanish () Indian () Japanese () Chinese () Korean () French () German () Other			
Employment Status: () Full-Time () Part-Time () Unemployed () Self-Employed () Retired () Active Military Student Status: () Full-Time Student () Part-Time Student () Not a Student Do You Have a Living Will? () Yes () No			
Pharmacy Name:	Pharmacy Address:	Pharmacy Phone #:	