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PATIENT INFORMATION FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

Sex: **M**ale or **F**emale Transgender: **MTF** or **FTM** DOB: _____

Languages: _____ Race: _____ Ethnicity: _____

Marital Status: (Circle One) Single Married Partner Divorced Widowed

Height: _____ Weight: _____

Address: _____
(Street Address) (City) (State) (Zip)

Home Phone: (_____)_____ May we leave a Message? YES or NO

Cell Phone: (_____)_____ May we text you? YES or NO

Work Phone: (_____)_____ May we call you at Work? YES or NO

Email Address: _____SS #:_____

Occupation/Employer:_____

Preferred Pharmacy: _____

Emergency Contact

Name: _____ Relation:_____
Emergency Contact Number: (_____)_____

Primary Care Physician: _____

Phone Number: (____)_____ Fax : (____)_____

Referred By (if any): _____

How did you hear about us? _____

Health Insurance Information (Primary Carrier)

Subscriber's Name:_____

Subscriber's DOB: ___ _____Relation to Subscriber:_____

Subscriber's SS Number: _____

ID Number: _____ Group Number: _____

Insurance Company: _____

Insurance Company Address: _____

City, State, and Zip: _____

Subscriber's Employer:_____

Secondary Insurance

Subscriber's Name:_____

Subscriber's DOB: _____Relation to Subscriber:_____

Subscriber's SS Number: _____

ID Number: _____ Group Number: _____

Insurance Company: _____

Insurance Company Address: _____

City, State, and Zip: _____

Subscriber's Employer:_____

****A copy of your insurance card or cards is required****

Please list all ***personal*** past medical history: _____

Please list first-degree family past medical history:
(**Please list which family member**)

Please list past surgical history: _____

Please list medications and dosages you are currently taking: _____

Please list any allergies: _____

Please list hormones you are currently taking or have previously taken: _____

What are you currently using for birth control? (Please circle)

Birth Control Pill Tubal Ligation Menopause IUD Hysterectomy
Abstinence Vasectomy Other: _____

Are you or your partner currently trying to get pregnant? YES or NO

Are you a current smoker? YES or NO

Do you use Alcohol? YES or NO

Do you exercise regularly? YES or NO