

Today's Date: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Nickname: \_\_\_\_\_ Suffix: \_\_\_\_\_ Gender:  Female  Male

Address: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Marital Status:  Single  Married  Separated  Partnered  Divorced  Widowed

Primary Language spoken:  English  other, specify \_\_\_\_\_

Ethnicity: Are you Hispanic/Latino?  Yes  No

Race:  American Indian or Alaska Native  Asian  Black or African American  
 Native Hawaiian or other Pacific Islander  White

Email: \_\_\_\_\_

		<b>Yes</b>	<b>No</b>
Home Phone: (____)_____	May we leave a detailed message:	<input type="checkbox"/>	<input type="checkbox"/>
Cell Phone: (____)_____	May we leave a detailed message:	<input type="checkbox"/>	<input type="checkbox"/>
Work Phone: (____)_____	May we leave a detailed message:	<input type="checkbox"/>	<input type="checkbox"/>
Preferred contact number?	<input type="checkbox"/> Home <input type="checkbox"/> Cell		

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about Barrett Clinic? \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Card provided **OR**

Provide Policy information:

Member #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy holder name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Card provided **OR**

Provide Policy information:

Member #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy holder name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Do you give Barrett Clinic permission to speak to anyone besides yourself about your healthcare?  No

Yes: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

OR

\_\_\_\_\_  
Signature of Parent/LAR/Power of Attorney/Guardian

\_\_\_\_\_  
Date