Integrative Family Health Clinic

Patient Information

Last Name:_____ First Name:_____ Middle Initial:___

Address:_____

_____

Date Of Birth:_____(MM/DD/YYYY) Age:_____

Social Security Number:_____

Occupation:_____

Genetic Gender: _____ Male _____ Female

Gender Identity if different than above:_____

Marital Status:__ Single __ Married __ Divorced __ Widowed __ Separated __ Domestic Partner __ Other

Contact Information

Cell Phone:_____

Home Phone:_____

Work Phone:_____

Email Address:_____

May we leave CONFIDENTIAL messages for you on any of these ?
Cell:____ Home:____ Email:____ No Thank You:____
Confidential messages include rescheduling, answering questions, ect. If you prefer to opt out, all that will be said in any and all messages to you would be requesting for you to give us a call.

Emergency Contact

Name:_____

Phone Number:_____

Relationship to Patient:_____

Additional Information

Race: __ White __ Hispanic __ American Indian/Alaska Native __ Black/African American __ Asian
__ Native Hawaiian/Pacific Islander __ Other __ Decline to Specify

Ethnicity: __ Hispanic/Latino __ Not Hispanic/Latino __ Decline to Specify

Employment Status: __ Employed __ Full-Time Student __ Part-Time Student __ Unemployed __ Retired

Smoking Status: __ Current every day smoker __ Current some days smoker __ Former Smoker __ Never Smoker

Preferred Pharmacy

Pharmacy Name:_____

Pharmacy Location:_____
_____

Pharmacy Phone:_____

How did you hear about us?

___ **Referral from existing patient**

___ **Referral from another healthcare provider**

___ **Google**

___ **Website**

___ **Advertisement**

___ **Facebook**

___ **Other, please specify**_____

Integrative Family Health Clinic

Insurance Information

Name of Insurance:_____

Member ID / Policy Number:_____

Group Number:_____

Name of Subscriber:_____

Subscriber Date of Birth:_____

Effective / Start Date:_____