EASTSIDE INTERNAL MEDICINE, PC

PATIENT INFORMATION

(PLEASE PRINT)

Patient Name: *(LAST)* *(FIRST)* *(MI)*

Street Address:	City:	State:	Zip Code:

Home Phone:	Cellular:	Work Phone: Ext:	Email:

What number/method would you prefer we use for appointment reminders and what time of day:

☐ *Home* ☐ *Work* ☐ *Cell-Call* ☐ *Cell-Text* ☐ *Morning* ☐ *Afternoon* ☐ *Evening*

DOB:	Sex: ☐ *M* ☐ *F*	Marital Status: ☐ *S* ☐ *M* ☐ *D* ☐ *W*	Social Security Number:

May we leave messages (ex: test results) on your voice mails?

☐ No If yes, which number(s)? ☐ Home: ☐ *Brief* ☐ *Extended* ☐ Cell: ☐ *Brief* ☐ *Extended*

Employment Status:

☐ *FT* ☐ *PT* ☐ *Self Employed* ☐ *Unemployed* ☐ *Retired*

Who should we contact in case of an emergency?

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship:_____ Phone:_____

Ethnicity:

☐ *White* ☐ *African American* ☐ *Asian* ☐ *Hispanic/Latino* ☐ *Native Hawaiian/Pacific Islander*

Preferred Language:

☐ English ☐ Other:_____

Please provide your primary pharmacy information:

Name:_____ Location: _____ Phone:_____

PRIMARY INSURANCE (please supply us with a copy of your card)

Insurance Company:	Effective Date:	Relationship to Subscriber: ☐ *Self* ☐ *Spouse* ☐ *Child* ☐ *Other*

Subscriber's Name: *(if other than self)*	Subscriber SSN:	Subscriber DOB:

SECONDARY INSURANCE *(please supply us with a copy of your card)*

Insurance Company:	Effective Date:	Relationship to Subscriber: ☐ *Self* ☐ *Spouse* ☐ *Child* ☐ *Other*

Subscriber's Name: *(if other than self)*	Subscriber SSN:	Subscriber DOB:

Patient Signature:_____ Date:_____

☐ *Updated* ☐ *No Changes* *Patient Signature:_____ Date:_____*

☐ *Updated* ☐ *No Changes* *Patient Signature:_____ Date:_____*

☐ *Updated* ☐ *No Changes* *Patient Signature:_____ Date:_____*

☐ *Updated* ☐ *No Changes* *Patient Signature:_____ Date:_____*