PATIENT INFORMATION

Account # _____ Date: _____

Patient Demographics

Patient Name: _____
LAST FIRST MIDDLE

Patient Sex: ☐ Male ☐ Female Date of Birth: _____

Address: _____
STREET CITY STATE ZIP

E-mail Address: _____

Legal Guardian Name *(if minor):* _____

Insurance Subscriber *(if not patient):* _____ Subscriber DOB: _____

Contact Preferences: *Please only list numbers you wish us to use to contact you/leave general messages/appointment reminders.*

Cell: _____ Home: _____ Work: _____

Primary Phone Type: ☐Cell ☐Home ☐ Work

Emergency Contact Name: _____ Emergency Contact Phone: _____

Previous Medical Treatment History:

Primary Pharmacy Name/City: _____

How did you hear of Lakeview Clinic? _____

Do you have a Primary Care Provider outside of Lakeview: _____

Name/Address of Doctor/Office where you were treated last: _____

_____

Race (select all that apply):

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ Other
- ☐ Decline to Specify

Ethnicity:

- ☐ Non-Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Decline to Specify

Primary Language: _____

If NOT English, do you require interpretation services? ☐ Yes ☐No