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PATIENT INFORMATION		Today's Date: _____
Last Name:	First Name:	Middle:
SS#:	Birth date:	Drivers Lic #
Mailing Address:		
City:	State:	Zip:
Primary Phone:	Secondary Phone:	email:
<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
EMPLOYER		
Name:		Position:
City:	State:	Zip:
Work Phone:		Fax:
How may we contact you? (check all that apply) <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> e-mail		
INFORMATION <input type="checkbox"/> SPOUSE or <input type="checkbox"/> PARENT (IF MINOR)		
Last Name:	First Name:	Middle:
SS#:	Birth date:	
Mailing Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
EMPLOYER		
Name:		Position:
City:	State:	Zip:
Phone:	Fax:	
EMERGENCY CONTACT PERSON NOT LIVING WITH YOU		
Last Name:	First Name	Middle:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Do you have an advance directive? <input type="checkbox"/> Yes <input type="checkbox"/> No Would you like to receive advance directive forms? <input type="checkbox"/> Yes <input type="checkbox"/> No		
ETHNICITY		
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline to Answer Preferred Language:		
RACE		
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Decline to Answer