

**PATIENT INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Married  Single  Other Sex:  Male  Female

NAME OF RESPONSIBLE PERSON (if patient is a minor): \_\_\_\_\_

RACE: American Indian/Alaska Native Asian Native Hawaiian Black/African American  
White Hispanic Other Race

ETHNICITY: Hispanic Non-Hispanic Refused to Report

LANGUAGES: English Other Indian (includes Hindi & Tamil) Spanish Russian

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone/Message \_\_\_\_\_

E-Mail Address: \_\_\_\_\_; confirm address: \_\_\_\_\_

Patient's Social Security Number (if a Minor, the Responsible Party) (SSN): \_\_\_\_\_

Detailed Messages (appointments, call back, labs, results, etc) may be left at Home Cell Phone

Patient Portal AllCare Web Communication (requires additional office setup) communications consent  
initial Yes or No: (Yes) \_\_\_\_\_ or (No) \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently using Health Insurance:  Yes  No

Name of Primary Insurance Company: \_\_\_\_\_

Group #: \_\_\_\_\_ ID # \_\_\_\_\_

Secondary Insurance Company (if applicable) \_\_\_\_\_

Do you have a Living Will?  Yes  No DNR/DNI: \_\_\_\_\_ Other Specific Code Status \_\_\_\_\_

Durable Medical Power of Attorney: \_\_\_\_\_ Guardianship: \_\_\_\_\_

**POLICY INFORMATION:**

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Employee: \_\_\_\_\_ SSN: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth(mm/dd/yy) \_\_\_\_\_ Sex:  Male  Female

**EMERGENCY CONTACTS:**

Primary Emergency Contact Name: \_\_\_\_\_

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

Secondary Emergency Contact Name: \_\_\_\_\_

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

**Do you have a doctor you see on a regular basis (PCP)? If so, whom; PLEASE LIST EVEN IF OUT OF STATE**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**How did you hear about AllCare? Who may we thank for your referral? CHECK ALL THAT APPLY**

Friend  Work  Hotel  Drive By  Co-Worker  Newspaper  Phone  Other \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Legal Guardian/Representative Signature (if Minor) \_\_\_\_\_ Date \_\_\_\_\_