Healthy Habits
wellness center

## PATIENT INFORMATION

Date: _____Preferred Pharmacy: _____

Patient Name: _____
(Last) (First) (Middle)

Preferred Name: _____ Maiden Name: _____Prefix: _____Suffix: _____

Date of Birth: _____ Sex: ❑ Female ❑ Male Social Security #:_____

Race: ❑ Caucasian/White
❑ African American/Black
❑ Asian
❑ American Indian/Alaskan Native
❑ Nat Hawaiian/Pacific Islander
❑ Declined
❑ Other

Ethnicity: ❑ Non-Hispanic/Latino
❑ Hispanic/Latino
❑ Declined

Primary Language: ❑ English
❑ Spanish
Other: _____

Marital Status: _____ Driver's License: _____Religion: _____

Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: Home: _____ Work: _____ Cell: _____ Primary: ❑ Home ❑ Work ❑ Cell

Fax: _____ Pager: _____ Email: _____

Preferred Communication Method: ❑ Email/Patient Portal ❑ Mail ❑ Phone-Cell ❑ Phone-Home ❑ Phone-Work

## EMERGENCY CONTACT

Please list closest relatives/friends, preferably not living at same address

Emergency Contact 1: _____

Home Phone: _____ Work Phone: _____ Relationship to Patient: _____

Emergency Contact 2: _____

Home Phone: _____ Work Phone: _____ Relationship to Patient: _____

## EMPLOYER INFORMATION

Employer: _____ Employment Status: ❑ Full time ❑ Part Time

Occupation: _____Employer Phone: _____

Employer Address: _____

## RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____
(Last) (First) (Middle)

Address: _____

Home Phone: _____ Work Phone: _____ Relationship to Patient: _____

Date of Birth: _____ Sex: ❑ Female ❑ Male Social Security #:_____

## PRIMARY INSURANCE

Insurance Company Name: _____ Insurance Phone: _____

Insurance Company Address: _____

Insurance Policy ID: _____ Group Name/Number: _____

Subscriber/Policy Holder Name: _____ Subscriber Date of Birth: _____

Subscriber SSN: _____ Subscriber Address: _____

Relationship to Patient: _____ Effective Date of Coverage: _____ Copay: $_____

## SECONDARY INSURANCE (if applicable)

Insurance Company Name: _____ Insurance Phone: _____

Insurance Company Address: _____

Insurance Policy ID: _____ Group Name/Number: _____

Subscriber/Policy Holder Name: _____ Subscriber Date of Birth: _____

Subscriber SSN: _____ Subscriber Address: _____

Relationship to Patient: _____ Effective Date of Coverage: _____ Copay: $_____