PATIENT INFORMATION FORM

How did you hear about our services: _____

Race: _____ White
_____ Black/African American
_____ American Indian
_____ Asian
_____ Hawaiian/Pacific Islander
_____ Other

Ethnicity:
_____Non-Hispanic/Non-Latino
_____ Hispanic/Latino

Marital Status: _____ Married
_____ Single
_____ Widow
_____ Divorced
_____ Separated

Student: _____ Yes, _____ (where)
_____ No

Emergency Contact Person: _____
Relationship: _____ Phone: (_____)_____

Do you have a primary health care provider? _____ Yes _____ No
Do you have a dental provider? _____ Yes _____ No
Are you under the age of 22 with a chronic illness? _____ Yes _____ No
Do you receive SSI benefits _____ Yes _____ No

Income Information

Date:			
Monthly or annual income (before taxes):			
Number supported by this income:			
Do you have health insurance?	Yes / No	Yes / No	Yes / No
Do you have dental insurance?	Yes / No	Yes / No	Yes / No
Do you have Forward Health? (Badgercare/FPOS)			
Payment Level (office use)			

Social Security #: _____ Forward Health #: _____

Best way(s) to contact you:
_____ Call cell _____ Call home
_____ Write home _____ Text _____ E-mail _____

Date of Birth: _____/_____/_____
Phone: Home(_____)_____
Cell (_____)_____
(_____)_____

Name: _____
Last First Middle Maiden

Address: _____
Street City Zip

(Office Use Only)

Confidential: _____ Yes _____ No Chart #: _____
Revised 01/2015