RescuingHealth

PATIENT INFORMATION **Today's Date:** _____

Name:_____**Preferred Name:**_____**Pronouns:**_____

DOB: _____ □ Male □ Female □ Other_____**SSN**:_____

Pharmacy: Name: _____Location:_____Phone #:_____

Race: □ American Indian/Alaska Native □ White □ Nat Hawaiian/Pacific Islander

□ Asian □ Black/African American □ Other Race □ Unknown □ Declined

Marital Status: □ Single □ Married □ Divorced □ Widow/Widower **Primary Language:** _____

Employer: _____ **Household Annual Income:** _____

Number of People in Household:_____Ethnicity: □ Declined □ Hispanic or Latino □ Other_____

Address:_____City/State:_____Zip_____
Home #:_____Work#:_____Cell#_____Primary #:_____
Email: _____

Primary Care Physician Name/Address/Phone #:_____

Specialist Name/Address/Phone#:_____

Do you have Health Insurance? □ Yes □ No – If **YES** please fill out the insurance information below:

PRIMARY Insurance: _____ Employer: _____

Policyholder Name: _____Date of Birth: _____SS#_____

Address: □ Same as Patient or _____
Relationship to Patient: □ Self □ Spouse □ Father □ Mother □ Other _____

SECONDARY Insurance:_____ Employer: _____

Policyholder Name: _____Date of Birth:_____SS#_____

Address: □ Same as Patient or _____
Relationship to Patient: □ Self □ Spouse □ Father □ Mother □ Other _____

Parent/Guardian Information ---- Please complete if Patient is a minor:

□ Father /□ Guardian Name: _____ Date of Birth: _____

Address: □ Same as Patient_____
Home#:_____Cell/Pager#:_____Work#:_____Employer: _____

□ Mother /□ Guardian Name: _____ Date of Birth: _____
Address: □ Same as Patient_____
Home#:_____Cell/Pager#:_____Work#:_____Employer: _____

Signature Verifying Accuracy of Information: _____ **Date**:_____