

Patient Information

First name: _____ MI _____ Last name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work phone: _____ (N/A)

Cell phone: _____ (N/A)

SEX: Male Female

AGE: _____

RACE: Hispanic/Spanish/Latino White

Date of birth (mo/date/yr): ____/____/____

Pacific Islander Black, African-Am.

Other (specify: _____)

ENGLISH 1ST LANGUAGE? yes no (if no, specify native language: _____)

If no, fluent in English? yes no

Reads in English? yes no

Writes in English? yes no

EDUCATION LEVEL:

HANDEDNESS: Right Left Mixed

MARITAL STATUS: Never married Married Widowed Divorced
 Separated

Number of years to current spouse: _____

PRIMARY OCCUPATION (past or current): _____

EMPLOYMENT STATUS: Retired Semi-retired Fully Employed

Employed Part-time Homemaker Disabled Unemployed

yes no

U.S. MILITARY VETERAN:

LIVING SITUATION:

Living Alone

Living with spouse/partner

Living with relatives other
than spouse/partner

Living friends or other non-
relatives

Living in assisted living
facility

Living in a nursing home

Living in a group home

Other (specify: _____)

Patient Information – continued

Are you currently employed? yes no

If yes,

Employer name: _____

Employer address: _____

Did someone refer you for this evaluation? yes no

Referring physician or other healthcare provider:

Name: _____

Address: _____

Phone: _____ Permission to correspond with above yes no

Other healthcare provider that you would like to receive results of this evaluation:

Name: _____

Address: _____

Phone: _____ Permission to correspond with above yes no

Insurance Information

Primary Insurance Name _____ Subscriber ID _____

Policy Holder's Name _____ Policy Holder's Date of Birth ___/___/___

Relationship to patient: Self Spouse Parent Other: _____

Policy Holder's Employer/Agency through whom you have coverage _____

Secondary Insurance Name, if any _____ Subscriber ID _____

Policy Holder's Name _____ Policy Holder's Date of Birth ___/___/___

Relationship to patient: Self Spouse Parent Other: _____

Policy Holder's Employer/Agency through whom you have coverage _____

Permission to bill for services on my behalf yes no

I understand that I am responsible for charges not covered by my insurer.

SIGNATURE

DATE: