Black River Health

Office Use Only

Date: _____ MRN: _____

PATIENT INFORMATION FORM

Please fill out all the questions to the best of your knowledge. This information will become a part of your medical record and is considered confidential.

PATIENT INFORMATION

Name: _____
Last First Middle

Maiden/Previous Last Name(s): _____

Date of Birth: ____/____/____ Social Security Number: _____

Address: _____ Home Phone: _____
Street

_____ Mobile Phone: _____
City State Zip

Email Address: _____

Sex: ☐ Female ☐ Male ☐ _____

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Other: _____

Race:
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Choose not to state
- ☐ _____

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Choose not to state
- ☐ _____

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ _____

Name of Spouse: _____
Last First Middle

Spouse's Date of Birth: ____/____/____ Spouse's Social Security Number: _____

Employer: _____

Employer Address: _____
Street

_____
City State Zip

Employer Phone: _____

Employment Status:
- ☐ Full-Time
- ☐ Part-time
- ☐ Self-Employed
- ☐ Not Employed
- ☐ Active Military Duty

Are you retired? ☐ Yes ☐ No If yes, what date did you retire? ____/____/____

Are you disabled? ☐ Yes ☐ No If yes, what date were you declared disabled? ____/____/____

EMERGENCY CONTACT

Name: _____
Last First Middle

Address: _____ Phone: _____
Street

_____ Relationship: _____
City State Zip

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FOR MINOR (CHILD UNDER 18)

Parent/Guardian 1 Name: _____
Last First Middle

Date of Birth: ____/____/____ Social Security Number: _____

Address: _____ Phone: _____
Street

_____ Relationship: _____
City State Zip

Employer: _____ Employer Phone: _____

Parent/Guardian 2 Name: _____
Last First Middle

Date of Birth: ____/____/____ Social Security Number: _____

Address: _____ Phone: _____
Street

_____ Relationship: _____
City State Zip

Employer: _____ Employer Phone: _____

HEALTH INSURANCE INFORMATION

Are you insured? ☐ Yes ☐ No

Are you the policy holder? ☐ Yes ☐ No

If no, relationship to policy holder: _____

Name of Insurance Company: _____

Policy Number: _____ Member Number: _____

Policy Holder Employer: _____

☐ Please provide insurance card for validation with completed form.