Scanned _____

NEIL A. PATTERSON, M.D., P.A.

First Name:	Middle Initial:	Last Name:	Previous/Maiden Name

Street Address (No./Name):	City:	State:	Zip Code:

Telephone #s: (H)_____
(C)_____
(W)_____
Email: _____

Date of Birth:

Gender: M F
Transgender

Marital Status: Single Married Partner
Divorced Widowed Legally Separated

Social Security Number:	Employer:

Employment Status: F/T P/T Self Military
Retired Student F/T Student P/T None

In case of emergency, indicate the nearest friend or relative whom we may contact for you:

Name:_____ Relationship:_____ Telephone #(s):_____

Address: _____

Race: White Black Hispanic Asian American Indian Native Alaskan Native Pacific Islander Other

Ethnicity: Non-Hispanic
Hispanic

Primary Language:
☐ Needs interpreter

Residence Type: Private Home or Apartment
Residential Home or Dormitory
Skilled Nursing Home
Nursing Home

Subscriber Information: (Complete if other than patient)

First Name:_____ MI:____Last Name:_____

Address (Street No./Name, City State, Zip):_____

_____

Date of Birth:_____ **Social Security No.:** _____

Telephone No.: (Home)_____ (Work) _____ Employer: _____

MINORS ONLY:

Information On Party Who Is <u>Legally</u> Responsible For Payment Of Services:

First Name:_____ MI:____Last Name:_____

Address (Street No./Name, City State, Zip):_____

_____

Date of Birth:_____ **Social Security No.:** _____

Telephone No.: (Home)_____ (Work) _____ Employer: _____

Custodial Parent(s) or Legal Guardian(s):

Please list all people over age 18 who may accompany the minor for office visits and <u>make decisions regarding medical care</u>. Please indicate their relationship to the minor. **Please note that medical records and information will only be released to these entities**