# PATIENT QUESTIONNAIRE

FIRST NAME: _____ MI: ____ LAST NAME: _____

ADDRESS: _____ GENDER: ☐ M ☐ F

CITY: _____ STATE: _____ ZIP: _____ PREFERRED LANGUAGE:

EMAIL: _____ ☐ ENGLISH

SOCIAL SECURITY #: _____ BIRTHDAY: _____ ☐ SPANISH

ETHNICITY (not required): □ HISPANIC/LATINO □ NOT HISPANIC/LATINO ☐ OTHER

RACE (not required): ☐ WHITE ☐BLACK/AFRICAN AMERICAN ☐ ASIAN

☐ HISPANIC ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ OTHER

PRIMARY PHONE: _____ ☐ HOME ☐WORK ☐CELL

SECONDARY PHONE: _____ ☐HOME ☐WORK ☐CELL

PREFERRED METHOD OF CONTACT: ☐TEXT ☐ EMAIL ☐PHONE

GUARDIAN'S NAME IF MINOR: _____

GUARDIAN'S ADDRESS IF DIFFERENT: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐DIVORCED ☐WIDOWED

EMPLOYMENT STATUS: ☐ EMPLOYED ☐DISABLED ☐RETIRED ☐PART TIME

EMPLOYER: _____ PHONE #: _____

SCHOOL (STUDENTS): _____

EMERGENCY CONTACT: _____ PHONE #: _____

EMERGENCY CONTACT RELATIONSHIP: _____

PRIMARY CARE DOCTOR: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PRIMARY PHARMACY YOU USE: _____ LOCATION: _____

MAY WE CONTACT YOUR PHARMACY TO OBTAIN YOUR MEDICATION LIST? ☐YES ☐ NO

PERSON RESPONSIBLE FOR BILL: _____

NAME RELATIONSHIP

NAME OF INSURED: _____ INSURED'S BIRTHDAY: _____

PRIMARY INSURANCE: _____ PHONE #: _____

CO-INSURANCE: _____ PHONE #: _____

## ASSIGNMENT TO BENEFITS

I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

Signed (Patient, or guardian if minor) _____ Date: _____

## RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process this claim.

Signed (Patient, or guardian if minor) _____ Date: _____

## PAIN MANAGEMENT DISCLAIMER

Appropriate treatment of medical conditions requires the physician to be aware of all current care you are receiving. Please fill out the section below:

☐ I AM currently enrolled in Pain Management Pain Clinic: _____

☐ I AM NOT currently enrolled in Pain Management

Signed (Patient, or guardian if minor) _____ Date: _____

## RELEASE OF MEDICATIONS

I authorize the undersigned physician to electronically access my medications from all prescribing physicians.

Signed (Patient, or guardian if minor) _____ Date: _____

## ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature