

SALUTATION: MR / MRS / MS / MISS / DR / _____

GENDER: MALE / FEMALE

NAME _____

MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED

ETHNICITY: WHITE / AFRICAN AMERICAN / HISPANIC / OTHER _____

PREFERRED LANGUAGE: ENGLISH / SPANISH / FRENCH / OTHER _____

DATE OF BIRTH ____ / ____ / ____ **SOCIAL SECURITY #** ____ / ____ / ____

LOCAL ADDRESS _____

LOCAL HOME # () _____ **CELL #** () _____

WORK # () _____ **EMAIL** _____

SEASONAL ADDRESS _____

SEASONAL PHONE # () _____

DATES OF SEASONAL TRAVEL _____

LIVE IN ASSISTED LIVING FACILITY? YES/NO **ARE YOU IN REHAB/SKILLED NURSING?** YES/NO

NAME AND NUMBER OF FACILITY _____

EMERGENCY CONTACT _____ **PHONE #** () _____

RELATIONSHIP TO YOU _____ **CONSENT TO SPEAK TO FAMILY** YES / NO

REFERRED BY _____

PRIMARY CARE DR. _____ **PHONE #** () _____

CARDIOLOGIST _____ **PHONE #** () _____

PHARMACY / LOCATION / PHONE # _____

EMPLOYER _____

INSURANCE CO. _____ **PPO / HMO / OTHER** _____

POLICY HOLDER NAME _____ **DOB** ____ / ____ / ____

SECONDARY INSURANCE CO. _____