

Patient Name Preferred Name Date of Birth Sex (M/F/T) Preferred Pronouns

Home Address: No. Street City State Zip

PATIENTS 13 YEARS and OLDER

Patient Phone: _____
 Patient Email: _____

ONLINE PATIENT PORTAL (MyChart)

Yes, I want access to my MyChart
 No, I do not want access.

PARENT/GUARDIAN INFORMATION

<p>Name Relationship to Pt</p> <p>Address</p> <p>Home Phone Cell Phone</p> <p>Employer Work Phone</p> <p>Parent Email (print clearly)</p> <p>ONLINE PATIENT PORTAL (MyChart) <input type="checkbox"/> Yes, give me access. My D.O.B: _____ <input type="checkbox"/> No, do not give me access</p>	<p>Name Relationship to Pt</p> <p>Address</p> <p>Home Phone Cell Phone</p> <p>Employer Work Phone</p> <p>Parent Email (print clearly)</p> <p>ONLINE PATIENT PORTAL (MyChart) <input type="checkbox"/> Yes, give me access. My D.O.B: _____ <input type="checkbox"/> No, do not give me access</p>
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PHARMACY

Pharmacy Name Street Address (#) City

INSURANCE AND PAYMENT INFORMATION

Insurance Name: _____

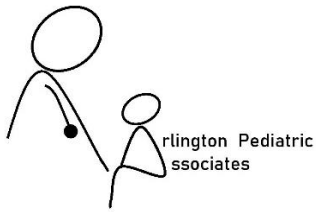
Subscriber: _____ Subscriber DOB: _____

Name of person responsible for balances unpaid by insurance if **NOT** subscriber:

Name: _____ DOB: _____

SIGNATURE (parent or patient if over 18)

DATE



The categories listed below provide a minimum standard for maintaining, collecting and presenting data on race and ethnicity for Federal reporting purposes.

Race; Please check all that apply (up to 3):

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other, please Specify _____
- Unknown
- Decline to Answer**

Ethnicity; Please check one:

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown
- Decline to Answer**

Preferred Language; Please check one:

- English
- Other, please specify: _____
- Decline to Answer**

Written Language; Please Check one:

- English
- Other, please specify: _____
- Decline to answer**

PATIENT NAME: _____

DATE OF BIRTH: _____