Patient Information (Please Print) **CHART# _____**

Name: _____ Date of Birth: _____

First Middle Last

Street Address: _____

City/State/Zip: _____

Phone # (Please list at least 2 numbers, and put your preferred number on #1)

Phone #1: _____ Phone #2: _____ Phone #3: _____

Email Address: _____

Employer: _____☐Full-time ☐Part-time

Race: _____ Ethnicity: _____ Gender: ☐Male ☐Female ☐Other

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Insurance Information (☐check here if same as above)

Subscriber: _____ Date of Birth: _____

Subscriber Address: _____

Subscriber Phone #: Home: _____ Work: _____ Cell: _____

Relationship: _____ Employer: _____

Emergency Contact Information

Name: _____ Relationship: _____

Phone #: Home: _____ Work: _____ Cell: _____

Communication

Preferred Language Spoken: _____

Is your vision impaired? ☐Yes ☐No Is your hearing impaired? ☐Yes ☐No

If so, how can we best facilitate communication? _____

Do you have a Living Will or Advanced Directives? ☐Yes ☐No

If so please provide a copy for our records; if not please feel free to discuss with your provider.

Would you like an invitation to join our patient portal? ☐Yes ☐No

I acknowledge that I have been given the opportunity to read and review the Notice of Privacy Practices for Raleigh Family Practice, P.A.

Signature: _____ Date: _____