

Patient Information Sheet

Name (Legal) _____ **Date of birth** _____

What Name do you use? _____

Today's date: _____

Gender: _____ Optional

Pronouns: _____ No pronoun preference

Sexual Orientation: _____ Optional

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home phone: (_____) _____ **Cell phone:** (_____) _____

Email address: _____

Preferred mode of contact: Home Cell Email **May we leave messages?** Y N

May we text you? Y N **May we call you at work?** Y N **What hours?** _____

Local pharmacy: _____ **Mail order pharmacy:** _____

Relationship status: Single Partner Married Divorced Widowed Other Decline

Partner/spouse name: _____

Who lives with you? _____

Housing type: Apt House Dorm RV Mobile Home Homeless Asst Living Other

Pets? Y N **What type?** _____

Employment status: Full-time Part-time Student Self-employed Retired
Unemployed Disabled Other

Employer _____ **Phone** (_____) _____

Address _____ **City** _____ **Zip** _____

Emergency contact name: _____ **Relationship:** _____

Home phone: (_____) _____ **Cell phone** (_____) _____

Emergency contact name: _____ **Relationship:** _____

Home phone: (_____) _____ **Cell phone** (_____) _____

May we discuss your health or care with a family Member? Y N

With whom? _____ **Phone** (_____) _____

With whom? _____ **Phone** (_____) _____