PATIENT INFORMATION FORM

(PLEASE PRINT)

PATIENT NAME (LAST, FIRST, MI) _____ DATE _____

STREET ADDRESS _____ SSN _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

EMAIL _____ DATE OF BIRTH _____ SEX (M/F) _____

MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

SPOUSE NAME _____ SPOUSE PHONE _____

PATIENT'S PRIMARY CARE PHYSICIAN (PCP) _____ PCP PHONE _____

REFERRING PHYSICIAN _____ REFERRING PHYSICIAN PHONE _____

PREFERRED FORM OF CONTACT: ☐ Home Phone ☐ Cell Phone ☐ Email

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____ PHONE _____

☐ I give RRC permission to share my medical information with my emergency contact & spouse.

☐ I am insured under an active insurance plan. ☐ I am a Self-Pay patient.

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