

# PATIENT INFORMATION QUESTIONNAIRE

## 1 *Personal Information*

Name \_\_\_\_\_ Date \_\_\_\_\_  
Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Preferred Name \_\_\_\_\_  
\_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Minor \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Referred by \_\_\_\_\_

## 2 *Responsible Party*

**Who is responsible for the account?**

Name \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Birthdate \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. # \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

## 3 *Telephone*

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. # \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
Where do you prefer to receive calls? \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Cell  
When is the best time to reach you? Time \_\_\_\_\_ Days \_\_\_\_\_  
In the event of an emergency, who should we contact:  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_