PATIENT INFORMATION SHEET
INFORMACION DEL PACIENTE

NAME
NOMBRE_____

DATE OF BIRTH
FECHA DE NACIMIENTO_____

GENDER
SEXO_____

ADDRESS
DIRECCION_____

CITY
CUIDAD_____

STATE
ESTADO_____

ZIP CODE
ZONA POSTAL_____

SOCIAL SECURITY #
SEGURO SOCIAL_____

TELEPHONE #
TELEFONO_____

EMAIL ADDRESS
CORREO ELECTRONICO_____

PARENT/LEGAL GUARDIAN
PADRES O TUTOR LEGAL_____

EMPLOYER
EMPLEADOR_____

TELEPHONE #
TELEFONO_____

ADDRESS
DIRECCION_____

CITY
CIUDAD_____

STATE
ESTADO_____

ZIP CODE
ZONA POSTAL_____

EMERGENCY CONTACT PERSON
CONTACTO DE EMERGENCIA_____

TELEPHONE #
TELEFONO_____

ADDRESS
DIRECCION_____

CITY
CIUDAD_____

STATE
ESTADO_____

ZIP CODE
ZONA POSTAL_____

RELATIONSHIP
PARENTESCO_____

WHAT LANGUAGE DO YOU WANT TO BE SERVE UNDER?
QUE LENGUAJE QUIERRE QUE LE HABLEMOS?

☐ English ☐ Spanish ☐ Vietnamese ☐ Other _____
Ingles Espanol Vietnamita Otro _____

HOW MANY PEOPLE ARE IN YOUR HOUSEHOLD?
CUÁNTAS PERSONAS VIVEN EN SU CASA? _____

WHAT IS YOUR MONTHLY INCOME?
CUÁL ES SU INGRESO MENSUAL? _____

ETHNICITY
ÉTNICIDAD**:** ☐ Hispanic/Latino ☐Not Hispanic/Latino
Hispano/Latino No Hispano/Latino

WHAT IS YOUR SOURCE OF INCOME?
CUÁL ES SU FUENTE DE INGRESO? _____

RACE
RAZA**:** ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ American Indian
Asiático Hawaiano Nativo Otras Islas del Pacifico Indigeno norteamericano

☐ White ☐ African American ☐ More than One Race
Americano Afro Americano Mas de Una Raza

AUTHORIZATION: To pay benefits to physician; I hereby authorize payment of any insurance benefits, covering these medical charges, directly to the Physician/Surgeon. I further understand that although I may have insurance, I am responsible for payment of this account regardless of insurance coverage.

PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE
FIRMA DEL PACIENTE/PARIENTE O TUTOR_____

DATE
FECHA_____