Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____ Marital Status: _____

Sex: _____ Date Of Birth: _____ SS#: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Street Address: _____ City: _____State: _____ Zip: _____

Patient Referred By:_____ Patient Primary Care Physician: _____

Email address: _____

Preferred Pharmacy: _____ Phone: _____

Preferred Laboratory: _____

Preferred Language: _____

Race: ☐ Arab ☐ Black or African American ☐ White ☐ Other ☐ Declined

Ethnicity:

☐Central America ☐Cuban ☐Dominican ☐Hispanic or Latin ☐Latin America/Latin ☐Not Hispanic or Latino ☐Puerto Rican ☐South American ☐Spaniard ☐Declined

Advance Directive:

Do you have an advanced directive (living will/power of attorney)?____Yes ____ No; If yes, please provide a copy

How did you hear about us?

☐Physician ☐Internet Search ☐ Newspaper ☐Television ☐Hospital Partner ☐BHS Screening Bus ☐Baptist Community Event ☐Website ☐Insurance Company ☐Baptist Emergency Hospital ☐Friend/Family ☐Employer ☐Other _____

Guardian Information

Last Name: _____ First Name: _____ Middle Initial: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Employer Information

Employer Name:_____ Employer Phone: _____

Street Address:_____ City: _____ State _____ ZIP: _____