P.R.I.M.A., Inc. Patient Information Sheet

Patient's Full Name: ____ DOB: ________ SEX: ______
Patient's Full Name: ____ DOB: ________ SEX: ______
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Patient's Full Name: ____ DOB: ________ SEX: ______

*__STEP 1:__ *Please fill in the requested information below.*

Race: _____________________________________ Refuse to answer: ☐
Language: _________________________________ Refuse to answer: ☐
Ethnicity: Hispanic ☐ Non-Hispanic ☐ Refuse to answer: ☐

Mother's Name:__________________________________ **DOB:** _____________
Mother's Employer: __________________ Employer Telephone: _____________
Father's Name:__________________________________ **DOB:** _____________
Father's Employer: ___________________ Employer Telephone**:** ___________

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*__STEP 2__: *Please take a few moments to review the information we have on file for this patient.*
If any of this information has changed, please use the space provided to make the necessary changes.
Please make sure that all boxes are checked if the information has not changed.

☐ (CHECK IF THE SAME) **Primary Telephone Number:** «HomePhone»
New Primary Phone: ____
☐ (CHECK IF THE SAME) **Secondary Telephone Number**: «CellPhone»
New Secondary Phone Number: ____
☐ (CHECK IF THE SAME) **Tertiary Telephone Number**: «WorkPhone»
New Tertiary Phone Number: ____

☐ (CHECK IF THE SAME) **Email**: «Email»
New Email:____

☐ (CHECK IF THE SAME) **Home/Mailing Address**: «MailingAddress1»
«MailingAddress2»
New Home/Mailing Address: ____
____

***Alternate Home/Mailing Address (Fill in if applicable)**: ____
____

☐ (CHECK IF THE SAME) **Billing Address**: «GrAddr1»
«GrAddr2»
New billing Address: ____
____

☐ (CHECK IF THE SAME) **Emergency Contact Name (someone other than parents'):** «EmergencyName»
☐ (CHECK IF THE SAME) **Emergency Phone**: «EmergencyPhone»
New Emergency Contact Name: _________________________ Relation to Patient: ___________________
New Emergency Contact Number: ____

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*__STEP 3__: *After __reviewing or altering__ the above information, please sign and date below.*
Date: _______________
Signature of Patient or Legal Representative:____

OFFICE USE ONLY
Check if information is updated in computer: ☐
Staff initials: _______