OakLeaf CLINICS

Thank you for choosing OakLeaf Clinics!
To better care for you, we need the following information.
Please Print. All information will be confidential.

PATIENT INFORMATION

Patient's Legal Name (Last): _____ (First): _____ (MI): ____

Preferred First Name: _____ Maiden Name/Previous Names: _____

SSN: _____ ☐ Male ☐ Female Birthdate: _____

Address: _____ City: _____ County: _____ State: ___ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Please check one: ☐ Minor ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed ☐ Separated

Language: ☐ English ☐ Spanish ☐ Hmong ☐ Other_____ ☐ Decline

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Decline

Race: ☐ White ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American
☐ American Indian ☐ Native American or Alaska Native ☐ Decline

Who is your Primary Care Physician/Provider? _____

Employer: _____ Work Phone: _____

If patient is a student, name of school/college: _____

If married, Spouses' Name: _____ Phone: _____

If Minor, Parents' Name: _____ Phone: _____

Parents' Address: _____ City: _____ County: _____ State: ___ Zip: _____

If Minor, Parents' Name: _____ Phone: _____

Parents' Address: _____ City: _____ County: _____ State: ___ Zip: _____

Emergency Contact Name: _____ Phone: _____

Who may we thank for referring you? _____

RESPONSIBLE PARTY

Name of person responsible for this account: _____ Relationship to Patient: _____

Address: _____ Home Phone: _____

Birthdate: _____Employer: _____ Work Phone: _____

INSURANCE INFORMATION *(Required unless you are self-pay.)*

Primary Insurance: _____ID #: _____ Group #: _____

Policy Holder: _____ Policy Holder's Address: _____

Employer: _____ Work Phone: _____ Relationship to Patient: _____

Birthdate: _____ SSN: _____ Effective Date: _____

Secondary Insurance: _____ID # _____Group #_____

Policy Holder: _____ Policy Holder's Address: _____

Employer: _____ Work Phone: _____ Relationship to Patient: _____

Birthdate: _____ SSN: _____ Effective Date: _____