EG Healthcare

DATE _____

PATIENT INFORMATION					
Patient's Last Name:	First:	Middle:	Gender: (circle) M F T: FTM – MTF Sexual Orientation:		
Preferred Name (if different than above	Birth Date:	Preferred Language:			
Email:	Occupation: ☐Retired ☐Disabled ☐Student				
Street Address:	Apt#	City/Town	State	Zip Code	
Mobile Phone:	Home Phone:	Work Phone:			
RACE:	☐ American Indian/Alaska Native Black or African American	☐ Native Hawaiian/Pacific Islander ☐ Hispanic or Latino	☐ Asian ☐ White	☐ Other ☐ Decline to answer	

PHARMACY:		
PHARMACY NAME:	ADDRESS:	PHONE NUMBER

INSURED INFORMATION (IF DIFFERENT THAN PATIENT)					
Insured's Last Name:	Insured's First:	Middle:	Gender:	Age:	Birth Date:
Mobile Phone:	Work Phone:				
Employer:	Street Address:	City/Town:	State:	Zip Code:	

EMERGENCY CONTACT		
Name:	Relationship to Patient:	
Primary Phone:	Secondary Phone:	

IS THERE ANYONE ELSE YOU WOULD LIKE TO LIST?

☐PRIMARY CAREGIVER ☐HEALTH CARE PROXY ☐ OTHER

Name:	Relationship to Patient:	Phone Number:

PLEASE TELL US WHAT OTHER PROVIDERS ARE TAKING CARE OF YOU?
(FOR EXAMPLE. CARDIOLOGIST, DERMATOLOGIST, OR ANY OTHER SPECIALIST)

Name of Provider	Address	Phone Number
Name of Provider	Address	Phone Number
Name of Provider	Address	Phone Number

SOCIAL DETERMINANTS OF HEALTH

Are you homeless? (please circle) YES NO

Is there a friend, relative, or neighbor who could take care of you for a few days if necessary? (please circle)

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Family Friends Community Services None			
PEDIATRIC PATIENTS AGE 2-18 FILL THIS SECTION PARENT/LEGAL GUARDIAN			
PEDIATRIC PATIENT NAME:			
MOTHER Last Name:	MOTHER First Name:	MOTHER Maiden Name	MOTHER Birth Date
MOTHER: Address			MOTHER: Cell #
FATHER: Last Name	FATHER First Name:	FATHER: Birth Date	FATHER: Cell#
FATHER: Address			
GUARDIAN: (other than parent) First Name:	GUARDIAN: Last Name	GUARDIAN: relationship to the child:	GUARDIAN: Cell #
GUARDIAN : Address			
CHILD RESIDES WITH ☐MOTHER ☐FATHER ☐GUARDIAN ☐OTHER			