# Patient Information

Last Name_____FirstName_____ MI_____

Address _____ City _____ State_____ Zip_____

Phone (Home) _____ (Work)_____ ( Cell)_____

Email_____

Date of Birth____/____/_____ Age_____ Gender: □Male □Female

Social Security # _____Driver's License #_____

Referred by: _____

Ethnicity (check one) □Hispanic or Latino □Not Hispanic or Latino □I chose not to specify

Race (check one)

□Caucasian □African American □Hispanic □American Indian/Alaskan Native □Asian

□Native Hawaiian or other Pacific Island □Other □I chose not to specify

Marital Status: □Single □Married □Divorced □Widowed □Separated □Other

Name of Spouse or Parent : _____ Phone Number _____

Occupation_____

Employer _____ Phone Number _____

Address _____ City _____ State_____Zip_____

Emergency Contact Information:

Full Name _____ Relationship:_____

Phone Number:_____

I, _____, agree to be treated by Dr. Matthew J. Bauman.

_____ _____

Signature of patient or legally responsible adult Date