Milliken Medical Patient Information Form

Date:_____

Full Legal First Name:_____ Last Name_____ MI_____ (please print)

Previous Name (if any):_____

Mailing Address:_____City_____Zip_____

Date of Birth:_____ Gender: ___M ___F

Primary Care Physician:_____

Last 4 digits of your Social Security Number:_____

Primary Phone Number:_____ Home __ Cell__ Work__

Secondary Phone Number:_____ Home __ Cell__ Work__

Preferred Pharmacy:_____ City:_____

Secondary Pharmacy:_____ City:_____

Would you like to sign up for our secure Web Portal? _____ Yes _____No **If Yes**, please provide us with your **Email Address**: _____

Race: ____White ___Hispanic ___Native American ___African American
___ Asian ____Other

Ethnicity: ____Non-Hispanic/Latino ___Hispanic/Latino

Language: ____English ___Other

Please list below the names of individuals that we may release to and/or discuss your protected health information with:

_____
Name Phone Number Relationship to you

_____
Name Phone Number Relationship to you

_____
Name Phone Number Relationship to you

Emergency Contact: Please check here if same as above _____

_____
Name Phone Number Relationship to you

Please initial the following

1. Consent to scan your photo from your state ID or license _____
2. Consent to obtain Rx history from pharmacy _____

Signature:_____ Date:_____