DIABLO FAMILY PHYSICIANS

WE ARE TRANSITIONING ELECTRONIC HEALTH RECORD SYSTEMS. THE FOLLOWING INFORMATION IS REQUIRED.

Patient Name: _____ DOB: _____ Sex: _____

Preferred Name: _____

Address: _____ City: _____ Zip: _____

Cell: _____ Home: _____ Work: _____ **Circle Preferred Number**

Email: _____ (PLEASE GIVE)

Primary Care Physician: _____

Emergency Contact: Name: _____ Phone: (___) _____

Relationship: _____

Patient Employment: Full Time Part Time Student Retired Self

PLEASE **CIRCLE** WHERE APPLIES:

1. **Need Interpreter:** Yes No
2. **Preferred Language**: English Spanish Chinese Russian Other_____
3. **Marital Status**: Single Married Divorced Widowed
4. **Written Language**: English Spanish Chinese Russian Other_____
5. **Ethnicity**: Hispanic or Latino Not Hispanic or Latino Refuse
6. **Religion**: Christian Catholic Jewish Baptist Muslim Buddhist Hindu

   Other_____
7. **Race**: American Indian Asian African American Native Hawaiian Caucasian

   Other _____ Refuse
8. **Insurance Subscriber**: Self Spouse Parent Other _____

   a. Name _____ DOB_____
9. **If Underage, Guarantor**: Name_____ Relationship_____ DOB_____

Please make sure to fill out all three registration forms. Thank you!