Blackhawk MEDICAL GROUP

Date:

PATIENT INFORMATION

Patient Name (Last, First, Initial)			**Home Phone #:**	**Cell Phone #:**
Home Address:			**City & State:**	**Zip:**
DOB:	**Gender:**	**Marital Status:** **M S W Div**	**SSN:** **LEAVE BLANK**	**DL#:**
Email:		**Your BMG PCP:**		
Employment Status: FT PT Retired Not Working		Employer:		Work Phone #:
Employer Address:			City & State:	Zip:
Emergency Contact Name			**Relationship:**	Phone #:
Preferred Pharmacy Name / Location:			**Phone #:**	**FAX#:**
RESPONSIBLE PARTY/GUARANTOR if different from above or the patient is a minor:				
Name:			**Relationship:**	**Date of Birth:**
Address:			City & State:	Zip:
Email Address:			Phone #:	
Primary / Secondary Insurance Information: **PLEASE be Prepared to Provide Your Most Current Card At Every Office Visit**				
Other Required Information:				
Religion:	**Ethnicity:** **Non-Hispanic: _____** **Hispanic: _____**		**Preferred Language:**	**Written Language:**
Is an Interpreter Needed : Yes ____ No _____	**Race:**			

May we text you with appointment reminders? Yes No Cell phone: _____

May we leave messages on your home or cell phone (circle one or both) with results/personal health information or appointment reminders? Yes No (circle one)

Is there someone you would like to authorize to receive messages on your behalf? Please list name, relationship and phone number: _____

May we email you with test results or communication re: your health or appointments? Yes No
Email address: _____

I certify that the information I have provided is true and correct:

Signature: _____ Date: _____