**PATIENT INFORMATION INFORMACION DE PACIENT**

First Name/ Primer Nombre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name/ Segundo Nombre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name/ Apellido: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suffix/ Sufijo: \_\_\_\_\_\_\_\_\_

Date of Birth/ Fetcha de Nacimento: \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Sex/Sexo: \_\_\_\_\_\_\_\_\_\_ Race/Raza: \_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Language/ Idioma Preferido: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status/ Estado de Civil: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number/ Telefono: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Cell Phone/Celular 🞎 Home Phone/De Casa

Email/ Correo Electronico: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Communication/ Comunicacion Preferido: 🞎 Email/ Correo Electronico 🞎 Text/ Texto 🞎 Phone/Telefono

Street Address/ Direccion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/ Ciudad: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/ Estado: \_\_\_\_\_\_\_\_\_ Zip Code/ Codigo Postal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\* Mailing Address If Different From Address \* Direccion De Correo Si Es Diferente De La Direccion**

Mail Address/ Direccion de Correo: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/ Ciudad: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/ Estado: \_\_\_\_\_\_\_\_\_ Zip Code/ Codigo Postal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT CONTACTO DE EMERGENCIA**

Contact Name/ Nombre de Contacto: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number/ Telefono: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship/ Relacion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPONSIBLE PARTY PARTE RESPONSIBLE** \*If the patient is under the age of 18 \*Si el paciente es menor de 18 años

Name/ Nombre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship/ Relacion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number/ Telefono: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email/ Correo Electronico: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SMOKING STATUS ESTADO DE FUMAR**

🞎 Current Smoker 🞎 Never Smoker 🞎 Former Smoker 🞎 Fumador Actual 🞎 Nunca He Fumado 🞎 Ex Fumador

**To keep information secure we ask that you create a password that you will be able to provide when asked.**

**Para mantener su informacion segura le pedimos que aga una clave que los pueda dar cuando se le pregunté.**

**Password/ Clave:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? / Como se entero de nosotoros? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

