

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!