Counseling & Health Center

317 West “F” Street Ontario, CA 91762
Phone: (909) 391-3051 / Direct: (714) 325-5621 / Fax: (909) 391-3068

PATIENT INFORMATION SHEET

PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS

First Name _____

Middle Name / MI _____

Last Name _____

Social Security Number _____

Home Phone _____

Work Phone _____

Cell Phone _____

Marital Status _____

Patient Address Line 1 _____

Patient Address Line 2 _____

City _____

State _____

Zip _____

Sex _____

Date of Birth _____

Race _____

Ethnicity _____

Whom should we thank for your referral? _____

INSURANCE INFORMATION

Subscriber's Name _____

Primary Relationship to Insured _____

Primary Insurance Name _____

Primary Subscriber ID _____

Social Security Number _____

Date of Birth _____

Secondary Insurance Name _____

Secondary Subscriber ID _____

Pharmacy Used _____

--EMERGENCY CONTACT— INFORMATION ON NEAREST RELATIVE OR FRIEND

Emergency Contact Name _____

Emergency Contact Home Phone _____

Signature of Patient or Legal Guardian

Date

_____