## *Welcome to Chester County Primary Care!*

*We would like to take this opportunity to welcome you to our office and assure you that we will do everything we can to provide you with the best possible care. We want to work with you to create a healthcare plan to fit your lifestyle. We hope to create a partnership to help you feel empowered to live the healthiest life possible!*

### PATIENT INFORMATION FORM

Today's Date:____________________ □ New Patient □ Update

Name: ____________________________________________ Date of Birth:____________________

Home Address: ____________________________________________________________

City:________________________________State:______________Zip Code:______________________

Social Security Number (Necessary only for billing purposes):_____________-__________-______________________

*Home phone:_______________________________ *Cell phone:_______________________________

*Work Phone:_______________________________ Email:______________________________________

***Please circle the phone number you would like us to use as your PRIMARY contact phone***

Marital Status: □Single □Married □Divorced □Widowed □Legally Separated

Employer:____________________________________________________________________

LOCAL Pharmacy Name **and** Location:______________________________________________

**Race: (Select one or more)**

| | | |
|---|---|---|
| □ American Indian or Alaskan Native | □ Pacific Islander | □ Black/African American |
| □ Asian | □ Native Hawaiian or Other Pacific Islander | □ White |
| □ Asian Pacific American | □ Native American | □ Other |
| □ Subcontinent Asian American | □ Other | □ Undisclosed |

**Ethnicity: (Select one)**

□Hispanic or Latino □Non-Hispanic or Non-Latino □Undisclosed

**Preferred Language:**

□English □Spanish □Other:____________________

**Emergency Contact**

Name:____________________________________________________________________

Contact Phone Number(s)______________________________________________________

How are they related?:_______________________________________________________

**Additional Contact**

Nearest contact NOT living with you:__________________________________________

How are they related?________________________________________________________

Contact Phone Number(s)______________________________________________________

**If the patient is a minor:**

Name of responsible party:___________________________________________________

Relationship to patient:______________________________________________________

Address (if other than patient's)______________________________________________

City:_________________________________ State:___________ Zip Code:____________________

Phone Number(s):___________________________________________________________