PATIENT INFORMATION

Date: ____/____/_____

Name: _____ **Date of Birth:** ____/____/_____ **Sex:** ☐ M ☐ F

First Name *Middle Initial* *Last Name*

Home Address: _____ _____ _____

Street Address City, State Zip Code

Home Phone: (_____) _____ **Cell Phone:** (_____) _____ **Other Phone:** (_____) _____

Preferred Phone: ☐ Home Phone ☐ Cell Phone ☐ Other Phone

Marital Status: ☐ Married ☐ Divorced ☐ Legally Separated ☐ Life Partner ☐ Single ☐ Widowed ☐ Unknown

Race/Ethnicity: ☐ Asian-Pacific Islander ☐ Black-African American ☐ Caucasian ☐ Hispanic ☐ American Indian ☐ Eskimo ☐ Other _____

Primary Language: _____ **Religious Preference:** _____

Occupation: _____ **Social Security #:** _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Retired ☐ Active Military Duty

Do You Have Advanced Directives: ☐ Yes ☐ No **If Yes, please bring a copy to the hospital**

Emergency Contact: _____ **Relationship:** _____

First Name *Middle Initial* *Last Name*

Home Phone: (_____) _____ **Cell Phone:** (_____) _____ **Other Phone:** (_____) _____

Address: _____ _____ _____ _____

Street Address City, State Zip Code

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Colorectal Care Center

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