



**PrimaryPlus Information Form**

Medical Record# \_\_\_\_\_  
(office use only)

**LEGAL NAME:** \_\_\_\_\_  
Last First Middle Maiden

**Preferred Name:** \_\_\_\_\_ **Social Security:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Preferred Provider/Clinician:** \_\_\_\_\_  
(This is the provider that you primarily want to see and to manage your overall care)

**Your Address:** \_\_\_\_\_  
Street City State/Zip Code

**Preferred Pharmacy:** \_\_\_\_\_

Do you speak and understand English? Yes No

**Gender:** (circle one) Male Female Transgender Other Choose not to disclose

**Assigned sex at birth:** (circle one) Male Female Choose not to disclose

**Pronouns:** (circle one) he/him she/her they/them

**Sexual orientation:** (circle one) Lesbian or gay Straight (not lesbian or gay) Bisexual

Something else Don't know Choose not to disclose

**Marital Status:** (circle one) Single Married Divorced Widowed Separated

**Race:** (circle one) White Black Asian American/Indian **Ethnicity:** Hispanic Non-Hispanic  
(If biracial, circle the race you most identify as)

**Contact Information: (Please list numbers and options we may use to contact you)**

Home Phone : \_\_\_\_\_ Cell/Mobile Phone: \_\_\_\_\_

Consent to call? Yes No Consent to text? Yes No

Consent to leave message? Yes No Consent to call? Yes No

Work Phone: \_\_\_\_\_ Consent to call? Yes No Consent to leave message? Yes No

Email Address: \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Veteran Status:** Veteran Non-Veteran

**Agricultural Work Status:** Non-Agricultural Employed Year-Around Seasonal Migrant Retired Farmer

**Homeless Status:** Do you consider yourself homeless? Yes No

**Public Housing:** Yes No patient declined

Insurance: \_\_\_\_\_ Private Insurance \_\_\_\_\_ Medicare \_\_\_\_\_ Medicaid \_\_\_\_\_ Self Pay/No Insurance

**Primary Insurance:**

**Insured/ Spouse Information**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Emergency Contact Information:**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

**Primary Caregiver** (if applicable): \_\_\_\_\_ DOB \_\_\_\_\_  
(Person who provides day-to-day care for the patient) Name

**Legal Guardian** (for minors): \_\_\_\_\_ DOB \_\_\_\_\_  
Name

Do you have legal documents? Yes No  
If yes, please submit appropriate documents to front desk staff

*(Non-applicable for children under the age of 18)*

Do you have a **Power of Attorney or Health Care Proxy/Surrogate?** Yes No  
(An "agent" designated by the patient, the patient's family, or by the courts to make health care decisions for him or her in the event that the patient is unable to do so)

If YES, please submit appropriate documents to front desk staff

Do you have a **Living Will or Advance Directives?** Yes No  
(Documents which give the patient a voice in decisions about their medical care when he/she is unconscious or too ill to communicate)

If YES: Please submit to front desk staff to be copied

If NO: And you would like additional information, please ask front desk staff for an informational packet

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_