LEGAL NAME: First______________________MI______Last_________________________________Nickname:____________

ADDRESS:_______________________________________CITY:_____________________________STATE:______ZIP:______

OTHER ADDRESS:________________________________CITY:________________________STATE:________ZIP:________

HOME PHONE:_______________________**WORKPHONE:**____________________**CELL PHONE**:_____________________

EMPLOYER:____ **OCCUPATION**______________________________________

YOUR SOCIAL SECURITY #:___________________________ **YOUR DATE OF BIRTH**:______________________________

YOUR EMAIL ADDRESS:________________________________

RACE: ☐White, ☐Black/AfricanAmerican, ☐ Hispanic/Latino, ☐Asian, ☐Other____________, ☐Decline to Answer
PREFERRED LANGUAGE:☐English, ☐Spanish,☐Indian,☐Japanese, ☐Chinese, ☐Korean, ☐French, ☐German, ☐__________
ETHNICITY: ☐ Hispanic/Latino, ☐Not Hispanic/Latino, ☐Decline to Answer

WHO IS YOUR FAMILY OR PRIMARY DOCTOR?____

PREFERRED METHOD OF CONTACT: ☐ Home Phone ☐Cell Phone ☐Work Phone ☐ Email ☐ Text ☐ Mail
If preferred method is text, name of cell phone company____

IF SPOUSE IS PRIMARY INSURED FOR YOUR INSURANCE:

SPOUSE NAME:_______________________________________ SPOUSE CELL/WORK NUMBER:________________________

SPOUSE'S DOB:____________________ SPOUSE'S EMPLOYER:____

SPOUSE / INSURED SS#________________________ (**Spouse's information is for insurance and identification purposes only**)

EMERGENCY CONTACT:(If not spouse listed above)

NAME:______________________________RELATIONSHIP:____________________________PHONE#:___________________

HOW DID YOU LEARN ABOUT OUR PRACTICE?____

ARE YOU PREGNANT? YES______ NO_______

By my signature, I attest that the above information is accurate and complete to the best of my knowledge. I have not been solicited or promised anything in exchange for healthcare services. I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service.

Signature:____ Date:_____________________________________

CONSENT TO TREAT AND EXAMINE A MINOR: I authorize Hollstrom & Associates, Inc physicians and whomever they designate as assistants to examine, x-ray, and administer appropriate care as they deem necessary to my child.

Signature of Parent or Guardian:____

Printed Name:____

Phone Number where you can be reached during the day:____