Dr. Scott Yarmark Dr. William Dickerman

Chart # _____ Date: _____ / _____ / _____

PLEASE FILL OUT AS MUCH INFORMATION AS POSSIBLE

PATIENT DEMOGRAPHICS:

First Name: _____ Middle Initial: _____ Last Name: _____

Parent/Guardian (**Under 18**): _____ Phone #: _____

DOB: _____ / _____ / _____ Sex: ☐ Male ☐ Female SSN: _____ - _____ - _____

PATIENT CONTACT INFORMATION:

Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Language: _____ Email: _____

Written Contact Preferences: ☐ Email ☐ Postal Mail

INSURANCE INFORMATION:

Primary Insurance Company: _____ CoPay: _____

Policy/ID #: _____ Group #: _____

Secondary Insurance Company: _____ CoPay: _____

Policy/ID #: _____ Group #: _____

Do you have a separate Prescription Rx Card: ☐ Yes ☐ No

INSURED PERSON *(IF NOT PATIENT)* – NEED ALL INFORMATION!

Name: _____ Phone #: _____ - _____ - _____

DOB: _____ / _____ / _____ SSN: _____ - _____ - _____

Street Address: _____ City/State: _____ Zip: _____

Relationship to patient: _____

Dr. Scott Yarmark Dr. William Dickerman

Race & Ethnicity Form

Please fill out ***completely***

Check/Circle *ALL* that apply

Race:
- White
- Black / African American
- American Indian / Alaska Native
- Asian (circle the most specific):
  - Asian Indian
  - Chinese
  - Filipino
  - Japanese
  - Korean
  - Vietnamese
  - Other Asian (specify): _____
- Native Hawaiian/Other Pacific Islander (circle the most specific):
  - Native Hawaiian
  - Guamanian or Chamorro
  - Samoan
  - Other Pacific Islander
- ALL other Races (please be specific): _____

Ethnicity:
- Hispanic or Latino (circle the most specific):
  - Mexican, Mexican American, Chicano/a
  - Puerto Rican
  - Cuban
  - Another Hispanic Latino/a or Spanish Origin: _____
- Not Hispanic or Latino

Marital Status: Never Married Married Domestic Partner Widowed Divorced

Employment Information:

Employment Status: _____ Employer Name: _____

Employer Phone Number: _____ - _____ - _____