East Valley
FAMILY
Physicians P.L.C.
Serving the Valley for Over 30 Years

EAST VALLEY FAMILY PHYSICIANS—PLEASE PRINT LEGIBLY—

PATIENT'S NAME _____
Last **First** **Mid Init**

PATIENT'S ADDRESS_____
Street **City/State** **Zip**

PATIENT'S _____
DOB **Sex** **SS#**

PATIENT'S E-MAIL ADDRESS _____

PATIENT'S EMPLOYER _____
Name **Phone No.**

EMPLOYER'S ADDRESS_____
Street **City/State** **Zip**

PATIENT'S CONTACT INFORMATION

What phone number should we use to contact you? Home_____ **Cell**_____

Is it ok to leave a message? **Yes** **or** **No** **(please circle one)**

In Case of Emergency Contact _____
Name **Relationship** **Phone No.**

PATIENT'S PHARMACY _____
Name **Phone** **Approximate Location**

PATIENT'S RACE (check)
_____ American Indian or Alaska Native
_____ Native Hawaiian or Pacific Islander
_____ White
_____ Refused to Report
_____Asian
_____Black or African American
_____ Hispanic
_____ Unreported

PATIENT'S ETHNICITY (check) _____Hispanic or Latino
_____ Refused to Report
_____ Not Hispanic or Latino

DO YOU HAVE ADVANCED DIRECTIVES???? (check) _____ Living Will _____Do Not Resuscitate

Language Spoken _____

Signature _____ **Date** _____

NAME AND RELATIONSHIP OF WHOM WE MAY DISCUSS MEDICAL INFORMATION WITH

1._____ relationship _____ Phone No _____

2. _____ relationship _____ Phone No _____