Wichita Diabetes & Endocrinology LLC

Patient Information

Last Name: ______________________________

First Name: ______________________________

Middle Name: ____________________________

Address: ________________________________

City: _____________________ State: _________

Zip: ______________________

Home Phone: ____________________________

Work Phone: ____________________________

Mobile Phone: ___________________________

Sex: _____________________________________

Date of Birth: ___________________________

Social Security No.: ______________________

Patient Email: ___________________________

Would you like to receives text messages?

□Yes □No

Would you like to receive an email invitation to our patient portal?

□Yest □No

Emergency Contact Information

Name: ___________________________________

Relationship: _____________________________

Phone: __________________________________

Employer Information

Employer: _______________________________

Address: ________________________________

Phone: __________________________________

Other

Patient Referred by: ______________________

Primary Care Provider: ____________________

Pharmacy [name and crossroads]:

____

____

Required by government mandate [although you may refuse]:

Preferred Language: ______________________

Race: ____________________________________

Ethnicity: ________________________________

Marital Status: ___________________________

To the best of my knowledge the above information is complete and accurate

Singed: ____ **Date:** _________________