DYNAMIC ARTHRITIS CARE CLINIC, PLLC
CARLOS E. RAMIREZ, M.D.
BOARD CERTIFIED INTERNAL MEDICINE & RHEUMATOLOGY

PATIENT INFORMATION

Last Name | First Name | Middle Initial | Nickname/Other Name

Home Address: Number & Street Name | Apt./Unit #

City | State | Zip Code

Home Phone | Cell Phone | Work Phone

Date of Birth | Gender ☐ M ☐ F | How did you hear about us? ☐ Physician ☐ Friend Name ____ ☐ Radio ☐ Magazine Which one? ____ ☐ Other ____

INSURANCE INFORMATION

Primary Care Physician | PCP Phone | Referring Physician | Ref. Physician Phone

Do you have health insurance? ☐ Yes ☐ No | Are you the insured or a dependent? ☐ Insured ☐ Dependent

Primary Insurance Company Name | Primary Insurance Address | Phone

Name of Insured: Last Name, First Name and Middle Initial (if patient is dependent) | Insured's Date of Birth

Insured's Address: Street, City, State & Zip (if different from patient) | Insured's Phone Number

Patient's relationship to insured | Name of Primary Parent/Guardian: Last Name, First Name & Middle Initial (if patient is a minor)

Secondary Insurance Company Name | Address | Phone

Name of Insured (if not patient) | Date of Birth | Relationship to patient

MEDICAL INFORMATION PREFERENCES

May we email you medical information or appointment reminders? ☐ Yes ☐ No Email Address: ____

May we leave messages regarding medical information or appointment reminders on your:
home phone? ☐ Yes ☐ No cell phone? ☐ Yes ☐ No work phone? ☐ Yes ☐ No **Brief Extended**

Race: ☐ White ☐ Black ☐ Asian ☐ Native American Indian ☐ Other | Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Pharmacy Name | Pharmacy Address: Number, Street, City and Zip | Pharmacy Phone

EMERGENCY & CONTACT INFORMATION

In case of emergency, who should we contact: Name | Home Phone | Other Phone | Relationship to patient

Are there other family members or persons with whom you authorize us to discuss your medical information? ☐ Yes ☐ No If yes:

Last Name, First Name, Middle Initial | Phone | Relationship

Last Name, First Name, Middle Initial | Phone | Relationship

SIGNATURE

Patient Signature | Date

I hereby affirm that I am the legal parent or guardian of patient and have authority to make decision regarding medical treatments.

Parent/Guardian: Last Name, First Name, Middle Initial | Parent/Guardian Signature