

Today's Date:		Gender: <input type="radio"/> Male <input type="radio"/> Female		MRN: (Office Use Only)	
First Name:		MI:	Last Name:		Birth Date:
Address:			City:		State: Zip:
Phone Number: () <input type="radio"/> Cell <input type="radio"/> Home <input type="radio"/> Okay to leave voicemail <input type="radio"/> Okay to text me <input type="radio"/> Do not call or text me		Email: _____ <input type="radio"/> Okay to email me <input type="radio"/> Do not email me			Your Occupation: _____
		Your Local Pharmacy Name: Cross Streets: City: _____ Phone #: _____			Primary Language: <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other: _____
Preferred Method of Contact? <input type="radio"/> Phone <input type="radio"/> Text <input type="radio"/> Email		Emergency Contact Person:			His or Her Phone Number:
Have you been to our clinic before? <input type="radio"/> No <input type="radio"/> Yes, When? _____ Under what name? _____					
How did you hear about us? (check one) <input type="radio"/> Internet: Google, MSN, Yahoo, BING, Twitter (please circle) <input type="radio"/> Friend/Relative <input type="radio"/> Facebook <input type="radio"/> Flyer <input type="radio"/> Sign <input type="radio"/> School: Nurse, Counselor, Teacher, Coach (please circle) <input type="radio"/> Agency <input type="radio"/> Medical Clinic <input type="radio"/> Church <input type="radio"/> 411 <input type="radio"/> Other: _____					
What outside services are you receiving? (check all that apply) <input type="radio"/> Medicaid <input type="radio"/> Food Stamps <input type="radio"/> WIC <input type="radio"/> Church <input type="radio"/> Community Clinic <input type="radio"/> Other _____					
Family Income Level: <input type="radio"/> Dependent <input type="radio"/> Unemployed <input type="radio"/> Welfare/SSI <input type="radio"/> \$0-\$14,000 <input type="radio"/> \$15,000-\$29,000 <input type="radio"/> \$30,000-\$44,000 <input type="radio"/> \$45,000-\$59,000 <input type="radio"/> \$60,000+ People related to you in your household (husband + kids): #: _____ <input type="radio"/> Decline to Specify	Marital Status: <input type="radio"/> Annulled <input type="radio"/> Divorced <input type="radio"/> Legally Separated <input type="radio"/> Married <input type="radio"/> Never Married /Single <input type="radio"/> Domestic Partner <input type="radio"/> Widowed <input type="radio"/> Decline to Specify	Religion: <input type="radio"/> Atheist <input type="radio"/> Buddhist <input type="radio"/> Christian <input type="radio"/> Judaism <input type="radio"/> Mormon <input type="radio"/> Catholic <input type="radio"/> Islam <input type="radio"/> Other: _____ <input type="radio"/> None <input type="radio"/> Decline to Specify	Ethnicity: <input type="radio"/> Decline to Specify <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino Race (check all that apply): <input type="radio"/> Black or African American <input type="radio"/> White <input type="radio"/> American Indian <input type="radio"/> Asian <input type="radio"/> Native Hawaiian or Other Pacific Islander <input type="radio"/> Other, Specify: _____ <input type="radio"/> Decline to Specify	Highest Level of Education Completed: <input type="radio"/> Middle School / Jr. High <input type="radio"/> High School/GED <input type="radio"/> Community College <input type="radio"/> College or University <input type="radio"/> Trade School <input type="radio"/> Graduate School <input type="radio"/> Decline to Specify	
My current insurance status is: <input type="radio"/> I have Private Insurance/PPO/HMO <input type="radio"/> I have Medi-Cal <input type="radio"/> I do not have insurance If I do not have my insurance card with me today, my Social Security Number is: _____ - _____ - _____					
Please be prepared to provide a copy of your driver's license and insurance card to an Obria staff member.					