Tidelands Health

Patient Information

Last Name			Primary Care Provider
First Name		Middle Initial	Referring Provider
Previous Name			Date of Birth (mm/dd/yyyy)
Address Line 1			Gender: ☐ Male ☐ Female ☐ Other
Address Line 2			Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed
City			Social Security Number
State	Zip		Employer Name
Home Phone Number	Cell Phone Number		Employee Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Unemployed
Work Phone Number	Ext.		Student Status: ☐ Full-time Student ☐ Part-time Student ☐ Not a Student
Emergency Contact Name	Relation		Emergency Contact Phone Number

Responsible Party or Guarantor (If under 18 years of age.)

Last Name		Relation		
First Name		Address		
Home Phone Number	Cell Phone Number	City	State	Zip

Advanced Directive Planning (A document explaining healthcare wishes if you were very sick and could not talk.)

Do you have an Advanced Directive?
☐ Living Will ☐ Medical Power of Attorney ☐ DNR ☐ I do not have an Advanced Directive. ☐ I would like more information.

Additional Information

Email	Do you want to participate in the Patient Portal? ☐ Yes ☐ No (The patient portal is a way to communicate electronically with your provider.)
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Black or African American ☐ White ☐ Hispanic ☐ Other ☐ Refuse to Report	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refuse to report

Employer Information

Employer Address	City	State	Zip

Pharmacy Information

Local Pharmacy Name	Pharmacy Telephone Number	Pharmacy Location
Mail Order Pharmacy Name		Mail Order Pharmacy Telephone Number