PATIENT DEMOGRAPHIC INFORMATION

*Please print clearly to ensure information is recorded correctly.

Today's Date: _____

_____ _____
Patient's Name (First, Middle, Last) Nickname

Mailing Address: _____ City, State, Zip: _____

Main Contact #: _____ Alternate #: _____ Work #: _____

Date of Birth: _____ /_____ /_____ Sex: O Male O Female O Non-binary SS#: _____

Marital Status: O Single O Married O Divorced O Widowed Occupation: _____

Primary Care Provider: _____ Phone #: _____

Would you like us to create a Patient Portal account for you? O *Yes* O *No* *Email:* _____

Employer: _____ Status: O Full-Time O Part-Time

Are you Retired? O Yes O No If yes, Retirement Date: _____ /_____ /_____

Are you Disabled? O Yes O No If yes, Disability Date: _____ /_____ /_____

Relationships

Guarantor/Person Responsible for Account: _____

Guarantor's Date of Birth: _____ /_____ /_____ Relationship to Patient: _____

Address: _____ Phone #: _____

Emergency Contact: _____ Relationship: _____

Phone #: _____ Emergency Contact Date of Birth: _____ /_____ /_____

Which racial category does the patient most closely identify with?

O African American O Asian O Caucasian O Hispanic
O Native American O Native Hawaiian O Pacific Islander O Other *(please specify)*: _____

What is the Patient's Ethnicity? O Hispanic or Latino O Not Hispanic or Latino

What is the Patient's Language Preference? O English O Spanish O Other *(please specify)*: _____

Insurance Information

Primary Insurance: _____ Member ID#: _____

Insurance Start Date: _____ /_____ /_____ Group#: _____

Subscriber/ Name of Policy Holder: _____ Date of Birth: _____ /_____ /_____

Secondary Insurance: _____ Member ID#: _____

Insurance Start Date: _____ /_____ /_____ Group#: _____

Subscriber/ Name of Policy Holder: _____ Date of Birth: _____ /_____ /_____

Complete if Patient is a MINOR

Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Name: _____ Relationship: _____