



Patient Demographic Information

PATIENT INFORMATION

Last name: _____ First name: _____ Middle initial: _____

If minor, name of responsible parent: _____

Name you would like to appear on your health records: _____

What are your pronouns: ☐ He/him ☐ She/her ☐ They/them ☐ Other: _____

DOB: _____ Social Security#: _____ Driver's License#: _____

Home address: _____ APT/suite#: _____

City: _____ State: _____ ZIP: _____

Phone number: _____ ☐ Mobile ☐ Home ☐ Work

Email address: _____

Do you think of yourself as:

☐ Male ☐ Female ☐ A category not listed here, please specify: _____

☐ Decline to answer

Occupation: _____ Employer: _____

EDUCATION, LANGUAGE & DEMOGRAPHICS

Highest level of education: _____

Preferred language: _____ Do you need an interpreter?: _____

Ethnicity: _____ Race: _____

IF APPLICABLE, NAME OF SPOUSE/DOMESTIC PARTNER

Last name: _____ First name: _____ Middle initial: _____

IF THE PATIENT IS LIVING IN A NURSING OR ASSISTED LIVING FACILITY?

Name of facility: _____

Address: _____ Room#: _____

City: _____ State: _____ ZIP: _____

CONTACT INFORMATION OF RESPONSIBLE PARTY/SPOUSE/PARENT (if info same as above, leave blank)

Last name: _____ First name: _____ Middle initial: _____
Social Security#: _____ Relationship to patient: _____
Address: _____ City: _____ State: _____ ZIP: _____
Phone number: _____ Email address: _____

EMERGENCY CONTACT			
Name		Relationship	Phone#
Address	City	State	ZIP

Who can we share your information with?

How did you hear about us?

Patient Signature: _____ Date: _____

Patient representative/parent: _____ Date: _____

For patients requiring translation or verbal reading of the document, the reader or translator may document and sign below.

Reader/translator: _____ Date: _____

BILLING INFORMATION & RESPONSIBLE PARTY/INSURANCE INFORMATION

Last name: _____ First name: _____ Middle initial: _____

INSURANCE INFORMATION	
Primary insurer	Name of insured
Insurance ID#/ Group#/ Other information	
Secondary insurer	Name of insured
Insurance ID#/ Group#/ Other information	
Pharmacy insurer	Name of insured
Insurance ID#/ BIN#/ PCN#/ Group#/ Other information	

Patient Signature: _____ Date: _____