



## 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 FOR RESPONSIBILITY 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: \_\_\_\_\_