PINNACLE
RHEUMATOLOGY

Patient Demographic Form

LAST NAME _____ FIRST NAME _____ MIDDLE_____

PRIMARY PHONE _____ DOB _____ AGE _____ SS# _____

SECONDARY PHONE _____ EMAIL _____

MAILING ADDRESS _____ APT/UNIT CITY _____ STATE _____

ETHNICITY: HISPANIC_____ NON-HISPANIC_____ RACE_____ DECLINE_____

PRIMARY PHYSICIAN _____ REFERRING PHYSICIAN _____

PHARMACY (LOCAL) _____ MAIL ORDER PHARMACY _____

PRIMARY LANGUAGE: English Other _____ MARITAL STATUS_____

EMPLOYER _____ OCCUPATION _____ STUDENT _____

EMERGENCY CONTACT _____ PHONE_____

Responsible Party (if not self):

LAST NAME _____ FIRST NAME _____ MIDDLE _____

ADDRESS _____ CITY _____ STATE_____ ZIP_____

RELATIONSHIP TO PATIENT _____ DOB _____ SS#_____

EMPLOYER _____OCCUPATION _____PHONE _____

Insurance Information:

POLICY HOLDER _____ DOB_____ SSN# _____

PRIMARY INSURANCE _____ ID# _____ GROUP# _____

INSURANCE PHONE _____ ADDRESS _____

PRIMARY INSURANCE _____ ID# _____ GROUP# _____

INSURANCE PHONE _____ ADDRESS _____

Signature of patient or guardian _____ Date _____