Destination Care
Family Medicine

PATIENT DEMOGRAPHIC INFORMATION

*Fields with * are required*

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#*:** _____ **Drivers license #*:** _____

Home address*: _____ **APT/suite #:** _____

City*: _____ **State*:** _____ **ZIP*:** _____

Pick one: **Home #*:** ◯ _____ **Mobile #*:** ◯ _____ (Checkmark the best number to use)

Email address*: _____

What is your gender:

- ○ Male
- ○ Female

Occupation: _____

Employer: _____

Phone #: _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

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 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: _____

Home #: _____ Cell #: _____ Email address: _____

PATIENT REFERRAL INFORMATON			
Patient referred by*			Phone #
Address	City	State	ZIP
Primary care physician*			Phone #
Address	City	State	ZIP

EMERGENCY CONTACTS (PLEASE PROVIDE TWO WITH DIFFERENT CONTACT INFORMATION)			
Name	**Relationship**		**Phone #**
Address	**City**	**State**	**ZIP**
Name	**Relationship**		**Phone #**
Address	**City**	**State**	**ZIP**

Who can we share your information with?

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	
Tertiary insurer*	Name of insured*
Insurance ID# / Group # / Other information	
Pharmacy insurer*	Name of insured*
Insurance ID# / BIN # / PCN # / Group # / Other information	

Patient signature: _____ Date: _____

For office use only:

Physician to be seen _____ **Date:** _____

Account number assigned: _____ **Initials:** _____

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