



## 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\*: \_\_\_\_\_

**Disclaimer:** While the information and guidance provided in this document is believed to be current and accurate at the time of posting, it is not intended to be and should not be construed to be or relied upon as legal, financial, or consulting advice. Before use, each document should be tailored to the unique nature of your practice, including applicable state law. Consult with an attorney and other advisors. References and links to third parties do not constitute an endorsement or sponsorship by the AMA, and the AMA hereby disclaims all express and implied warranties of any kind in the information provided.

**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:** \_\_\_\_\_

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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 INFORMATION			
Patient referred by*			Phone #
Address	City	State	ZIP
Primary care physician*			Phone #
Address	City	State	ZIP

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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?
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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: \_\_\_\_\_

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## 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: \_\_\_\_\_

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For office use only:

Physician to be seen

Date:

Account number assigned:

Initials:

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