CARE FOR YOU
MEDICAL CENTER
MARGATE

PATIENT DEMOGRAPHIC INFORMATION

First Name

Middle Name / MI

Last Name

Date of Birth

Social Security Number

Language

Ethnicity

Race

Patient Address Line 1

Patient Address Line 2

City

State

Zip

Home Phone

Cell Phone

It is ok to leave a message:

◯ Home Phone ◯ Cell Phone ◯ Both ◯ Neither

Email

Sex

Identifiable Gender

Sexual Orientation

◯ Straight/Heterosexual ◯ Lesbian, Gay, or Homosexual ◯ Bisexual ◯ Something else ◯ Don't Know ◯ Decline to specify

If "Something else", specify

Marital Status

US Citizen

◯ Yes ◯ No

Permanent Resident

◯ Yes ◯ No

Household Size

Annual Income

Income Source & Employer

Emergency Contact Name

Emergency Contact Cell Phone

INSURANCE INFORMATION

Do you have insurance?

◯ Yes ◯ No

Primary Insurance Name

Name of Insured

Insurance Obtained By

◯ Employer ◯ Affordable Care Act ◯ Self

Primary Subscriber ID

Primary Group No.

Copay Amt

Do you have a secondary insurance?

◯ Yes ◯ No

Secondary Insurance Name

Secondary Subscriber ID