

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\*:** |       |

**Do you think of yourself as:**
[ ]  Male [ ]  Female [ ]  Transgender man/trans man [ ]  Transgender woman/trans woman
[ ]  Genderqueer/gender nonconforming, neither exclusively male nor female

|  |  |  |
| --- | --- | --- |
| [ ]  A category not listed here, please specify: |       | [ ]  Decline to answer |

**Do you think of yourself as:**
[ ]  Straight or heterosexual [ ]  Lesbian or gay [ ]  Bisexual [ ]  Queer, pansexual and/or questioning

|  |  |  |
| --- | --- | --- |
| [ ]  An orientation not listed here, please specify: |       | [ ]  Don’t know [ ]  Decline to answer |

|  |  |
| --- | --- |
| **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**       |

|  |
| --- |
| **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:** |       |

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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:** |       |

For office use only:

|  |  |  |  |
| --- | --- | --- | --- |
| **Physician to be seen** |       | **Date:** |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Account number assigned:** |       | **Initials:** |       |

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