Patient Demographic Information

(Please print clearly and complete entire form)

General Information

Name ______________________________________ **Date of birth** _____/_____/_____ **Age** __________ **Sex** ☐M ☐F

Street address ____________________________________ **City** _______________________ **State** _________ **Zip** __________

SSN ____________________________________ **Marital Status** ☐Single ☐Married ☐Divorced ☐Widowed

Cell phone *required* (________)________-______________ **Home phone** (________)________-______________

Email address *required for patient reminders* ____

Preferred language ____________________________________ **Ethnicity** ☐Hispanic/Latino ***OR*** ☐Not Hispanic/Latino

Race *mark one of the below options*

☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Native Hawaiian or Pacific Islander
☐White
☐Other race
☐Decline to specify

Insurance Information

Primary Insurance

Carrier ____ Policy holder name ____________________________________

Policy number/Subscriber ID ____ Group number ______________________

Policy holder date of birth _____/_____/_____ Policy holder relationship to the patient _______________________________

Secondary Insurance

Carrier ____ Policy holder name ____________________________________

Policy number/Subscriber ID ____ Group number ______________________

Policy holder date of birth _____/_____/_____ Policy holder relationship to the patient _______________________________

Responsible Party (required for all patients under 18)

Name ____ Birthdate _____/_____/_____

Street address ____________________________________ City _______________________ State _________ Zip __________

Phone number (________)________-______________ Relationship to patient ____