



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
☐ Gender queer/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: _____

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: _____

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: _____