Patient Demographics

Patient First Name _____ **Patient Middle Name** _____

Patient Last Name _____ **Patient Preferred Name** _____

Sex:

Male

Female

Other _____

Marital Status

☐ Married ☐ Divorced ☐ Single ☐ Widow

Ethnicity

☐ Hispanic ☐ Non-Hispanic ☐ Prefer not to say

Race

☐ American Indian or Alaska Native

☐ Asian or Pacific Islander

☐ Black or African American ☐ White

☐ Prefer not to say

Preferred Language _____

Date of Birth _____

Social Security Number _____ **Primary Phone** _____ **Cell Phone** _____

Email Address _____

Address _____ **Address 2** _____ **Zip** _____

City _____ **State** _____

Emergency Contact Info

Emergency Contact First Name _____ **Emergency Contact Last Name** _____ **Emergency Contact Phone** _____

Emergency Contact Relationship _____

Employment

Occupation _____ **Position** _____

Employment Type

☐ Full - Time ☐ Part - Time

Employer Name _____

Work Phone _____

Employer's Address **City** **State**

Zip _____

Do you have Insurance? Yes or No

Primary Insurance Policy Holder

☐ Self ☐ Spouse

☐ Father ☐ Mother

☐ Family ☐ Other

First Name of Primary Insured **Last Name of Primary Insured** **Insurance ID #**

Insurance Company Name **Group Name** **Group Number** **Birthdate of Primary Insured**

Primary Insured Relationship to Patient

Secondary Insurance Details

Subscriber ID #

Subscriber's Name

Relationship to patient

Subscriber's DOB

Group Name or #

Subscriber's SS#

IF YOUR INSURANCE REQUIRES AN AUTHORIZATION, PLEASE BE SURE YOU HAVE ONE CURRENT ON FILE OR YOU MAY NEED TO RESCHEDULE YOUR APPOINTMENT.

Guarantor's Information

Please complete the following if the person responsible for payment is someone other than the patient.

Name **Address** **Telephone**

City **State** **Zip**

Relationship to patient