Patient Demographic Form

Last Name: _____ First Name: _____ M.I: ___

Date of Birth: _____ Birth Sex: Male / Female SSN: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Preferred Phone: _____ Email: _____

Would you like access to the patient portal to access your health information? Yes / Decline

Primary Care Physician (PCP): _____

Would you like your PCP informed of your admit, transfer, or discharge? Yes / No

Advance Directive: Yes / No If yes, type(s): _____

Marital Status (Circle One): Single / Married / Divorced / Widowed / Partner / Separated

Primary Language: _____ Race: _____ Hispanic (Circle One): Yes / No

Patients Employer Name: _____

EMERGENCY CONTACT

If Emergency Contact is Responsible Party, please check box. ☐

Name: _____ Date of Birth: _____

Primary Phone (if different): _____

Relationship to Patient: _____

RESPONSIBLE PARTY INFORMATION (IF PATIENT IS A MINOR)

1. Parent / Legal Guardian Name: _____

   Date of Birth: _____ SSN: _____

   Address (if different): _____

   Primary Phone (if different): _____

   Employer Name: _____

2. Parent / Legal Guardian Name: _____

   Date of Birth: _____ SSN: _____

PRIMARY INSURANCE

Insurance Name: _____

Insurance Address: _____

Insurance Phone Number: _____ ID #: _____

Insured's Name: _____ Date of Birth: _____ SSN: _____

Please present photo ID (i.e. Driver's Licenses, State Issued ID, Passport) and insurance cards to Registrar to be scanned into the system.

Employer: _____