

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: _____

Disclaimer: While the information and guidance provided in this document is believed to be current and accurate at the time of posting, it is not intended to be and should not be construed to be or relied upon as legal, financial, or consulting advice. Before use, each document should be tailored to the unique nature of your practice, including applicable state law. Consult with an attorney and other advisors. References and links to third parties do not constitute an endorsement or sponsorship by the AMA, and the AMA hereby disclaims all express and implied warranties of any kind in the information provided.



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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