Add logo here  
  
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:** |  |

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**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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