Patient Demographic Form

Please PRINT

Today's Date: _____

Last Name: _____ **First Name:** _____ **MI:** _____

Address: asfasfa _____ **City:** _____ **State:** _____

_____ **Zip:** _____

Preferred Phone Number: _____

☐Home ☐Cell ☐Work ☐Other: _____

Alternate Phone Number: _____

☐Home ☐Cell ☐Work ☐Other: _____

We are committed to providing quality services. Therefore, you may be contacted periodically by the business to confirm upcoming appointments and provide feedback regarding your experience. This contact may come via text or email; you can opt out anytime.

E-Mail Address: _____ ☐**Private**

Social Security Number: _____

Birth Date: _____ **Age:** _____

Marital Status: ☐Single ☐Married ☐Life Partner ☐Divorced ☐Widowed ☐Other: _____

Gender: ☐Female ☐Male ☐Additional category (please specify): _____

☐Decline to answer

<u>Emergency Contact</u>

Name: _____

Relationship: _____

Preferred Phone Number: _____

☐Home ☐Cell ☐Work ☐Other: _____

<u>Primary Care Physician</u>

Name: _____

Address: _____

City: _____ **State:** _____

Zip: _____ **Phone:** _____

Note: The below information and categories are requested as part of the Healthcare Reform Act

Race: ☐African American ☐American Indian ☐Asian ☐Caucasian ☐Hispanic ☐Pacific Islander ☐Other: _____ ☐Decline to answer

Ethnicity: ☐Hispanic, Latino or Spanish origin ☐Not Hispanic or Latino ☐Other: _____ ☐Decline to answer

Language: ☐English ☐Spanish ☐Other: _____

How Did You Hear About Us?

☐Billboard ☐Drive By ☐Social Media ☐Radio ☐Friend/Patient ☐Internet Search ☐Television ☐Word of Mouth ☐Insurance ☐Urgent Care/ER ☐Other: _____

☐Referring Physician

Name: _____

Address: _____

City: _____ **State:** _____

Zip: _____ **Phone:** _____