Patient Demographic Form

Patient Name: ____ Preferred Name: _______________

Social Security #: ______________________________ Date of Birth: ______________________________

Mailing Address: ____

City: ______________________________ State: _____________________ Zip: _____________________

Status: Single_____ Married_____ Divorced_____ Widowed_____ Sex: Male_____ Female_____

Driver's License #: ____________________ Phone #: __________________ Cell #: ________________

Email Address: ____

Emergency Contact Name and Number: ____

Employed [ ] Yes [ ] No Retired [ ] Yes [ ] No

Patient Employer: ____

Appointment reminders: Please choose one

[ ] **TEXT** to cell phone number listed above [ ] **EMAIL** to email address listed above

[ ] **Phone** call to the number listed above

Primary Insurance (please give your insurance card(s) to receptionist)

Primary Insurance: ___________________________ Subscriber's Name: _________________________

Subscriber's SSN: _________________________ Subscriber's DOB: ______________________________

Patients relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Contract/Member ID#: _____________________________ Group #: ______________________________

Secondary Insurance (please give your insurance card(s) to receptionist)

Secondary Insurance: ___________________________ Subscriber's Name: _______________________

Subscriber's SSN: ___________________________ Subscriber's DOB: ____________________________

Patients relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Contract/Member ID #: ______________________________ Group #: _____________________________

____ ______________________________

Print and signature of patient (if over 18) Date

____ ______________________________

Print and signature of guarantor (if patient is under 18) Relationship to patient