Patient Demographics

Scanned _____

First Name:	Middle Initial:	Last Name:	Previous/Maiden Name
Street Address (No./Name):	City:	County: State:	Zip Code:
Telephone #s: (H)_____ (C)_____ (W)_____ Email: _____	Date of Birth:	Gender: M F Transgender	Marital Status: Single Married Partner Divorced Widowed Legally Separated
Social Security Number:	Employer:	Employment Status: F/T P/T Self Military Retired Student F/T Student P/T None	

In case of emergency, indicate the nearest friend or relative whom we may contact for you:

Name:_____ Relationship:_____ Telephone #(s):_____

Address: _____

Race: White Black Hispanic Asian American Indian Native Alaskan Native Pacific Islander Other

Ethnicity: _____ **Declined to report** □	**1st Language**: _____ Needs interpreter Y N	**Residence Type**: Private Home or Apartment Residential Home or Dormitory Nursing Home

Subscriber Information: (Complete if other than patient)

First Name:_____ MI:____Last Name:_____

Address (Street No./Name, City State, Zip):_____

_____

Date of Birth:_____ **Social Security No.:** _____

Telephone No.: (Home)_____ (Work) _____ Employer: _____

MINORS ONLY:

Information On Party Who Is Legally Responsible For Payment Of Services:

First Name:_____ MI:____Last Name:_____

Address (Street No./Name, City State, Zip):_____

_____

Date of Birth:_____ **Social Security No.:** _____

Telephone No.: (Home)_____ (Work) _____ Employer: _____

Custodial Parent(s) or Legal Guardian(s):

Please list all people over age 18 who may accompany the minor for office visits and make decisions regarding medical care. Please indicate their relationship to the minor. **Please note that medical records and information will only be released to these entities**