# PATIENT DEMOGRAPHICS

**Patient Information:**

Social Security: ____________________

First Name: ____________________

Last Name: ____________________

Middle Name: ____________________

Preferred Name: ____________________

Birthday: __________ Gender: ☐ Female ☐ Male

Address: ____________________

City: __________ State: __________ Zip: __________

**Additional Information:**

**Primary Care Physician:** ____________________

Office Phone: ____________________

**Preferred Pharmacy**: ____________________

Pharmacy Phone: ____________________

Pharmacy Address: ____________________

**Emergency Contact Name:** ____________________

Relation to Patient: ____________________

Phone: ____________________

☐ **Check if address is the same as patient info.**

Address: ____________________

City: __________ State: __________ Zip: __________

**Parent or Legal Guardian (if applicable)**

First Name: ____________________

Last Name: ____________________

Relationship: ____________________

Primary Phone #: ____________________

Email: ____________________

☐ **Check if address is the same as patient info.**

Address: ____________________

City: __________ State __________ Zip __________

Home Phone: ____________________

Cell Phone: ____________________

Email: ____________________

**Information/Marketing Communication:** Yes ☐ No ☐

**Patient Reminders Communication:** Yes ☐ No ☐

**Preferred Method of communication:**

☐ No Preference ☐ Email ☐ Home Phone ☐ Cell Phone ☐ Mail

**Marital Status:**

☐ Child ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

Employer Name: ____________________

Employer Phone: ____________________

Employment Status: ☐ Disabled ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Student ☐ Not Employed

**Insurance Information (Guarantor)**

First Name: ____________________

Last Name: ____________________

Phone: ____________________

SSN: __________ DOB: __________

Gender: ☐ Female ☐ Male Relationship: __________

**Do you have insurance with more than one health plan?**

Yes ☐ No ☐

**Name of Secondary Insurance:** ____________________

☐ **Check if address is the same as patient info.**

Address: ____________________

City: __________ State: __________ Zip: __________

____________________

**Printed Patient\Legal Guardian**

____________________

**Patient\Legal Guardian Signature**

____________________

**Date**