

Faculty Group Practice Patient Demographic Form

Patient Information	Name (Last, First, MI)			Email address		
	Street Address			City		State
	Home Phone () Preferred <input type="checkbox"/>		Work Phone () Preferred <input type="checkbox"/>		Cell Phone () Preferred <input type="checkbox"/>	
	SSN	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Partner <input type="checkbox"/> Other		
	Race	Ethnicity		Preferred Language		Country of Origin
Financially Responsible Party	Is patient responsible party/guarantor? <input type="checkbox"/> Yes <input type="checkbox"/> No (If you are over the age of 18 and not in the care of an institution you are the guarantor as you are the person financially responsible for any charges you may incur during your visit)					
	Name		Address		City/State/Zip	
	Occupation		Employer		Email Address	
	Home Phone () Preferred <input type="checkbox"/>		Work Phone () Preferred <input type="checkbox"/>		Cell Phone () Preferred <input type="checkbox"/>	
Emergency Contact	Name			Relationship to Patient		
	Home Phone () Preferred <input type="checkbox"/>		Work Phone () Preferred <input type="checkbox"/>		Cell Phone () Preferred <input type="checkbox"/>	
Referral Info	Referring Physician's Name			Physician Phone/Fax (if known) ()		
	Physician Address					
PCP Info	Primary Care Physician's Name (Check if same as Referring Physician above <input type="checkbox"/>)			Physician Phone/Fax (if known) ()		
	Physician Address					
Insurance Information	Primary Insurance Company		Policy #		Group #	
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than patient)		
	Subscriber's Social Security #	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Employer of Subscriber		Work Phone ()
	Secondary Insurance Company		Policy #		Group #	
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than patient)		
	Subscriber's Social Security #	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Employer of Subscriber		Work Phone ()
<p>By signing below, I acknowledge that the information I provided is correct to the best of my ability.</p> <p>Patient Signature: _____ Date: ____/____/____</p> <p>Guarantor Signature (if other than patient): _____ Date: ____/____/____</p>						