



## Faculty Group Practice Patient Demographic Form

<b>Patient Information</b>	Name (Last, First, MI)						Today's Date		
	Street Address				City		State	Zip	
	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		Email address		
<b>Financially Responsible Party</b>	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		Relationship to Patient		
	Occupation		Employer		Email Address			Date of Birth	
	Home Phone ( ) Preferred <input type="checkbox"/>			Work Phone ( ) Preferred <input type="checkbox"/>			Cell Phone ( ) Preferred <input type="checkbox"/>		
<b>Emergency Contact</b>	Name				Relationship to Patient				
	Home Phone ( ) Preferred <input type="checkbox"/>			Work Phone ( ) Preferred <input type="checkbox"/>			Cell Phone ( ) Preferred <input type="checkbox"/>		
<b>Referral Info</b>	Referring Physician's Name					Physician Phone/Fax (if known) ( )			
	Physician Address								
	Do you have any advance directives that you would like to be a part of your medical record? ___ <b>YES</b> (please give to front desk) ___ <b>NO</b> *If you would like to learn more about advance directives, please ask the front desk for educational information & discuss with your MD.								
<b>PCP Info</b>	Primary Care Physician's Name (Check if same as Referring Physician above <input type="checkbox"/> )					Physician Phone/Fax (if known) ( )			
	Physician Address								
<b>Insurance Information</b>	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 ( )
By signing below, I acknowledge that the information I provided is correct to the best of my ability.									
Patient Signature: _____						Date: ____/____/____			
Guarantor Signature (if other than patient): _____						Date: ____/____/____			

