PATIENT DEMOGRAPHIC INFORMATION

Legal First Name:

Middle Name:

Legal Last Name:

Date of Birth (mm/dd/yyyy):

Sex: ☐ Male ☐ Female ☐ Undifferentiated

Race: ☐ White ☐ Hispanic ☐ African American
☐ American Indian ☐ Asian ☐ Other: _____

SSN:

Address 1:

Address 2:

City:

State: **Zip:**

Language:

Marital Status: ☐ Never Married ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Domestic Partner
☐ Other: _____

Pregnant: ☐ **YES** ☐ **NO**

EMPLOYMENT INFORMATION

Employment Status: ☐ Employed ☐ Unemployed
☐ Full-time Student ☐ Part-time Student
☐ Other: _____

Employer Name:

Employer Phone:

Address 1:

Address 2:

City:

State: **Zip:**

PATIENT CONTACT INFORMATION

Home Phone:

Work Phone: **Ext.**

Cell Phone:

Email:

Written Contact Preference: : ☐ Email ☐ Postal Mail

EMERGENCY CONTACT INFORMATION

First Name:

Last Name:

Emergency Phone:

Relation to Patient:

Address 1:

Address 2:

City:

State: **Zip:**

PRIMARY CAREGIVER

First Name:

Last Name:

Relationship:

LEGAL GUARDIAN

First Name:

Last Name:

Relationship:

HEALTHCARE PROXY

First Name:

Last Name:

Relationship: