

Faculty Group Practice Patient Demographic Form

Patient Information	Name (Last, First, MI)				Today's Date		
	Street Address			City		State	Zip
	Home Phone () <input type="checkbox"/> Preferred		Work Phone () <input type="checkbox"/> Preferred		Cell Phone () <input type="checkbox"/> Preferred		
	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"/> Single <input type="checkbox"/> Other			
	Race	Ethnicity	Preferred Language	Email address			
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		Relationship to Patient
	Occupation		Employer		Email address		Date of Birth
	Home Phone () <input type="checkbox"/> Preferred		Work Phone () <input type="checkbox"/> Preferred		Cell Phone () <input type="checkbox"/> Preferred		
Emergency Contact	Name				Relationship to Patient		
	Home Phone () <input type="checkbox"/> Preferred		Work Phone () <input type="checkbox"/> Preferred		Cell Phone () <input type="checkbox"/> Preferred		
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)				Physician Phone/Fax (if known)		
	Physician Address						
Insurance Information	Primary Insurance Co.				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 Co.				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: ____/____/____