Patient Demographics

First Name: _____ **MI:** _____ **Last Name:** _____ **Sex:** ○ Female ○ Male

Preferred Name: _____ **Maiden Name:**_____

DOB: _____/_____/_____ **SSN:** _____- _____ - _____

Race: (choose one) African American/Black American Indian/Alaskan Native Caucasian/White Nat Hawaiian/Pacific Islander

☐ Asian ☐ Decline ☐ Other: _____

Ethnicity: (choose one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated

Address: _____ **Apt. #:** _____

City: _____ **State**: _____ **Zip Code:** _____

Home Phone: _____**Work:** _____ **Cell:** _____

Primary Phone: (choose one) ☐ Home ☐ Work ☐Cell **Email:**_____

Emergency Contact #1 (First & Last Name): _____ **Relationship:** _____ **Phone Number:** _____

Preferred Pharmacy Name: _____ **Location:** _____

Family Doctor (First & Last Name): _____ **City:** _____ **State:** _____

Employer: _____ ☐ Full Time ☐ Part Time

Primary Insurance Coverage: _____

Policy Holder Name: _____ **Relationship to patient:** _____

DOB: _____/_____/_____ **SSN:** _____- _____ - _____ **Sex:** ☐ Female ☐ Male

Address: _____ **Zip Code:** _____

Contact Phone Number: _____ **Employer:** _____

Secondary Insurance Coverage: _____

Policy Holder Name: _____ **Relationship to patient:** _____

DOB: _____/_____/_____ **SSN:** _____- _____ - _____ **Sex:** ☐ Female ☐ Male

Address: _____ **Zip Code:** _____

Contact Phone Number: _____ **Employer:** _____

Tertiary Insurance Coverage: _____

Policy Holder Name: _____ **Relationship to patient:** _____

DOB: _____/_____/_____ **SSN:** _____- _____ - _____ **Sex:** ☐ Female ☐ Male

Address: _____ **Zip Code:** _____

Contact Phone Number: _____ **Employer:** _____