

PATIENT DEMOGRAPHICS

PATIENT INFORMATION		
PATIENT NAME:		
LAST	FIRST	MIDDLE
PREFERRED NAME:	GENDER: □ Male □ F	Female □ Trans Male □ Trans Female
PRONOUNS: ☐ She/Her ☐ He/H	lim \square They/Them \square Decline to Specify \square C	Other:
BILLING ADDRESS:		
STREET	CITY	STATE ZIP
HOME PHONE:	CELL PHONE:	
OTHER PHONE:	EMAIL ADDRESS:	
DATE OF BIRTH:	SSN: MA	ARITAL STATUS:
PRIMARY CARE PHYSICIAN:	REFERRING PHYSICHIAN:	
EMPLOYER:	OCCUPATION:	
RACE: ☐ American Indian / Alaska	an Native □ Asian □ Black or African Am	nerican 🗆 European 🗀 Hispanic
☐ Native Hawaiian or Othe	er Pacific Islander	Specify Other:
PARENT/GUARDIAN/SUBS	CRIBER (If patient is a minor OR If patient	is covered by another's insurance)
NAME:	RELATIONSHIP TO PATIENT:	
DATE OF BIRTH:	PRIMARY PHONE:	OTHER PHONE:
INSURED MEMBER'S SSN:	INSURED MEMBER'S EMPLOYER:	
EMERGENCY CONTACT		
NAME:	RELATIONSHIP TO PATIENT:	
PRIMARY PHONE:	OTHER PHONE:	
I understand that <u>I AM RESPONSIBLE</u> I authorize payment direct to my docto	ny insurance submissions. I authorize release of for paying my bill including any co-pays, co-insuror, and I permit a copy of this authorization to be used is responsible for the bill. We will provide a copy	ance, or deductible due on the date of service. used in place of the original. For minor patients,

PATIENT / GUARDIAN SIGNATURE: ______DATE: _____