



Patient Demographic Sheet

First Name: _____ M.I. _____ **Last Name:** _____

Patient Date of Birth: _____ **Patient Social Security Number:** _____

Mailing Address: _____

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

Home Phone: (____)-____-____ **Cell Phone:** (____)-____-____

Email: _____

Marital Status: ____ Single ____ Married ____ Legally Separated ____ Divorced ____ Widowed
____ Life Partner

Ethnicity/Race: ____ Alaska Native ____ African American ____ American Indian ____ Asian
____ Hawaiian Native ____ Hispanic ____ White ____ Other

Preferred Language: _____ **Religion:** _____

Patient has a Living Will? ____ Y ____ N **Patient has a DNR?** ____ Y ____ N

Emergency Contract (Parent/Guardian):

First Name: _____ M.I. _____ **Last Name:** _____

Home Phone: (____)-____-____ **Cell Phone:** (____)-____-____

Employment information: (Parent/Guardian)

Employer Name: _____ **Work Phone** (____) - ____ - ____

Employer Address: _____

Employment Status: ____ Full Time ____ Part Time

Insurance Information:

Primary Insurance Company Name: _____

Insurance Identification Number: _____ **Insurance Group Number:** _____

Subscriber Name: _____ **Subscriber Date of Birth:** _____

Secondary Insurance Company Name: _____

Insurance Identification Number: _____ **Insurance Group Number:** _____

Subscriber Name: _____ **Subscriber Date of Birth:** _____