Patient Demographic Form **Date:** _____

Patient Information

First Name:_____ Last Name:_____ DOB: _____ Gender: □ Male □ Female

□ Other:_____

Marital Status: □ Single □ Married □ Other: _____ Language: □ English □ Spanish □ Other:_____

Address:_____
(street) (city) (state and zip code)

Preferred Phone:_____ Can this receive texts? □ YES □ NO Can we leave voicemails? □ YES □ NO

Alternative Phone:_____ Email Address: _____

Emergency Contact:_____ Relationship to Patient:_____

Emergency Contact Phone:_____ May we contact for medical concerns? □ YES □ NO

If minor, who is responsible for billing? _____ Relationship to Patient: _____

Who else may we share medical information with?

1.Name:_____ Relationship to Patient:_____ Phone Number:_____
Leave a Voicemail: □ Yes □ No

Insurance Information

Insurance Name: _____ Employer:_____

Insurance Policy Holder:

Name:_____ DOB:_____ Phone Number: _____ Relationship to Patient:_____

Address (if not the same):_____
(street) (city) (state and zip code)

Secondary Insurance (Only if Medicare is primary): _____

NOTE: WE DO NOT BILL SECONDARY INSURANCE

Pharmacy Information

Preferred Pharmacy Name: _____ Street Address: _____ City: _____ State: ____

Other Preferred Pharmacy (if any): _____ Street Address: _____ City:_____ State: ____

Acknowledgment

Immunizations: Our medical records program allows your immunization data to be sent directly to the I-CARE State of Illinois Registry. I-CARE allows your provider to obtain your immunization history to ensure your safety. By signing this you authorize us to submit this data.

Electronic Prescriptions: Our medical record program accesses your prescriptions/medication history in order for us to safely prescribe your medications. By signing this, you authorize us to do so.

I confirm that the information provided is accurate and complete to the best of my knowledge. By signing this, I agree that I have received a HIPAA Acknowledgement Receipt.

Print Patient's Name:_____ Patient/Guardian's Signature: _____ Date: _____