Adult Patient Demographic Form

Please PRINT

PATIENT INFORMATION

Last Name	**First Name**	**Middle Initial**	**Nickname/AKA**
Date of Birth	**Social Security Number**		**Gender** ❑ Male ❑ Female
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Other			**Language** (if not English)
Race (Optional) ❑ Black – Non-Hispanic ❑ Caucasian – Non-Hispanic ❑ Hispanic ❑ American Indian/ Alaskan Native ❑ Asian ❑ Pacific Islander ❑ Other			

Home Address	**Apt #**	**City**	**State**	**Zip Code**
Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )		
Employer	**Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other			
Employer Address	**City**	**State**	**Zip**	
Name of School / College (if applicable)				
Email Address				

INSURED PARTY (Person who is Primary Insurance Holder)

Relationship to Patient

❑ Self (Medicaid/Medicare/Commercial Insurance) Continue to Next Section **❑ Self Pay (No Insurance) Continue to Next Section** **❑ Parent / Legal Guardian**

Last Name	**First Name**	**Middle Initial**		
Date of Birth	**Social Security Number**	**Relationship to Patient (please specify other)** ❑ Spouse ❑ Other		
Home Address	**Apt #**	**City**	**State**	**Zip Code**
Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )		
Employer	**Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other			
Employer Address	**City**	**State**	**Zip**	

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name	**First Name**	**Relationship to Patient**
Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )

OTHER EMERGENCY CONTACT INFORMATION – NOT LIVING WITH PATIENT

Last Name	**First Name**	**Relationship to Patient**
Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )