Patient Demographic Form

Patient Information

Patient Name	**Date of Birth**	**Sex (Circle)** M F
Street Address	**Apt.**	
City	**State**	**Zip**
Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )
SSN	**Marital Status (Circle):** Married Single Divorced Widowed Separated Partner	**Country of Origin**
Race (Circle): Black White Asian Decline to state Other	**Ethnicity (circle):** Hispanic Non-Hispanic Unknown	**Preferred Language**
E-mail address	**Occupation**	

Emergency Contact

Name	**Relationship to Patient**	
Street Address		
City	**State**	**Zip**
Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )

Responsible Party Information

Name	**Relationship to Patient**	
Street Address		
City	**State**	**Zip**
Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )

Referring Physician

Referring Physician's Name	**Physician's Phone** ( )
Physician's Address	
Is this primary care physician? ☐ **Yes** ☐ **No**	**If "No", please provide the following information:**
Primary Care Physician's Name	**Physician's Phone** ( )
Physician's Address	

Please present current insurance card. Patients will be billed for all services if insurance information is not available.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of account for any professional services rendered. By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature ______________________________ **Date** ______________

Guarantor Signature (if other than patient): ______________________ **Date** ______________