Patient Demographics & Contact Authorization

PATIENT INFORMATION

Last Name: ______________________________ First Name: ______________________________ Middle Initial: _____

Birth Date: __________________ Age: _____ Legal Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced

Gender Identity (*optional*): ________ Home Phone: _______________________ Cell Phone: _______________________

Street Address: ____

Address Line 2: _______________________________ City: __________________ State: ______ Zip Code: __________

INSURANCE INFORMATION

Insurance: _____________________________________ Member ID: ____

Policyholder/Subscriber: ____ DOB: ___________________________
(If patient is the holder, skip to the next section)

Relationship to Patient: ______________________________Policyholder Phone: _______________________________

Address (*if different from patient*): ____

Address Line 2: ____________________________ City: ______________________ State: ______ Zip Code: _________

Secondary Insurance: ________________________________ Member ID: _____________________________________

Policyholder/Subscriber: ____ DOB: ___________________________
(If the holder is same as above, skip to the next section)

Relationship to Patient: ______________________________Policyholder Phone: _______________________________

Address (*if different from patient*): ____

Address Line 2: ____________________________ City: ______________________ State: ______ Zip Code: _________

CONTACT AUTHORIZATION

Email Address: ____ **Enable Patient Portal?** ☐ Yes ☐ No

Messages for Appointment Reminders/Medical Information: ☐ ***Text*** ☐ ***Voice*** - Home / Cell ☐ ***Do Not Call***
(Circle One)

Emergency Contact:

Name:	**Phone Number:**	**Relationship to Patient:**	*Authorized to Discuss Medical Care?*
			☐ Yes ☐ No

Additional Contacts Authorized to Discuss Medical Care:

Name:	**Phone Number:**	**Relationship to Patient:**

I have verified all the above information and give my consent to contact me as noted in this document. Please note that it is your responsibility to contact us if any of this information changes.

Signature: ____ Date: ________________________________