

**Demographics**

**Patient Name** \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Home number \_\_\_\_\_ Cell number \_\_\_\_\_  
Email \_\_\_\_\_  
Date of birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Marital status: Married Divorced Single Widowed Unknown  
Employment status: Full time Part time Unemployed  
Student Retired Unknown  
Employer \_\_\_\_\_ Work number \_\_\_\_\_  
Occupation \_\_\_\_\_  
Spouse \_\_\_\_\_ Parents (if under 18) \_\_\_\_\_

**Preferred language** English Spanish other: \_\_\_\_\_  
**Race** American Indian/Alaska Native African American/Black  
Native Hawaiian/Pacific Islander Hispanic  
White Asian Unknown  
**Ethnicity** Hispanic/Latino Native Hawaiian/Pacific Islander  
Non-Hispanic/Latino Unknown  
**Communication preference** E-mail Telephone US mail

**Insurance**

Insurance company \_\_\_\_\_ (we need a copy of card to submit for you)  
**Insurance policy holder information: if same as patient leave blank**  
Name \_\_\_\_\_ Date of birth \_\_\_\_\_  
SSN \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Marital Status: Single Married Divorced Widowed Other  
Employment status: Full Time Part Time Retired Other

**Head of household: who is responsible for payment?**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

**Relatives at the same address: (we will only send one bill per household)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Thank you! We know these are not fun to fill out!