**Medical Demographics Form**

**Patient Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Last Name First Name Middle Initial*

**Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*# Street Name City State Zip Code*

**County:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Cell Phone** #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Work Phone #:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**E-Mail**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Method of Contact:** □ Home Phone □ Cell Phone □ Work Phone □ Mail □ E-Mail

**I would like to sign up to receive appointment reminders via cell phone text message:** □ Yes □ No

**Marital Status:** □ M □ S □ W □ D Maiden Name (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Gender:** □ F □ M

**Social Security #**:\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_**Employed: □ Full-time □ Part-time** **□ Student\_\_\_\_\_\_\_\_\_**

**Date of Birth**:\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ **City and State of Birth**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ethnicity: □** Non-Hispanic □ Hispanic **Preferred Language**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agricultural Worker**: □ Yes □ No **Veteran:** □Yes □ No

**Housing Status**: □ **Not Homeless** □ **Homeless Shelter** □ **Public Housing (Not Including Section 8)**

□ **Transitional** □**Other**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Provider**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_Pharmacy**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Guardian Name(s) if patient is a minor**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Relationship to Patient**: □ Parent □ Grandparent □ Foster Parent □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Primary Contact #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Secondary Contact** :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **(Mark all that apply to above )** □ Emergency Contact □ Primary Care Giver □ Legal Guardian □ Lives With |

**Name of Emergency Contact: (if different than above)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Emergency Contact #: (if different than above)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**