



## Patient Demographics

<b>Patient's Legal Name:</b>				Female ( )
Last:	First:	Middle Initial:		Male ( )
Mailing Address:		City:	State:	Zip:
Street Address:		City:	State:	Zip:
Home Phone (include area code) (      )	Current Marital Status (Circle One) Single    Married    Divorce    Widowed			Living Will? Yes ( ) No ( )
Cell Phone (include area code) (      )	Email Address:			
Patient Date of Birth:	Patient Social Security Number:	Primary Care Provider:		
Patient Employer:		Patient Work Phone (include area code) (      )		
Spouse's Name:	Spouse's Date of Birth:	Spouse's SSN (if Insured through Spouse):		
Emergency Notification (Not Living in Same Household) Name:		Emergency Notification Phone (include area code) (      )		

**\*\* RESPONSIBLE PARTY INFORMATION (Complete only if patient is a minor) \*\***

Responsible Party Relationship to Patient:	Responsible Party Home Phone (include area code) (      )		
Social Security Number:	Date of Birth:		
Mailing Address:	City:	State:	Zip:
Street Address:	City:	State:	Zip:

Race: ( ) White    ( ) American Indian or Alaskan Native    ( ) Native Hawaiian or other Pacific Islander    ( ) Asian  
           ( ) Black or African American    ( ) Declined

Ethnicity: ( ) Hispanic or Latino    ( ) Not Hispanic or Latino    ( ) Declined

Language: ( ) English    ( ) Spanish    ( ) Indian    ( ) Japanese    ( ) Chinese    ( ) Korean    ( ) French    ( ) German    ( ) Other

Employment Status: ( ) Full-Time    ( ) Part-Time    ( ) Unemployed    ( ) Self-Employed    ( ) Retired    ( ) Active Military

Student Status: ( ) Full-Time Student    ( ) Part-Time Student    ( ) Not a Student

Do You Have a Living Will? ( ) Yes    ( ) No

Pharmacy Name:	Pharmacy Address:	Pharmacy Phone #:
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How did you hear about our office? \_\_\_\_\_