PATIENT DEMOGRAPHIC SHEET

Thank you for completing this form, *our receptionist will assist you with all questions*. Your responses *will be kept confidential*.

PERSONAL INFORMATION

Today's Date: / /

Primary Doctor:	Date of Birth (mm/dd/yyyy):
Last Name:	Social Security Number:
First Name: Middle Initial:	Gender: ❑ Female ❑ Male
Previous Name:	Marital Status: ❑ Single ❑ Married ❑ Other_____
Mailing Address 1:	Spouse Name:
Street Address 2:	Employment Status: ❑ Full-time ❑ Part-time ❑ Not Employed
City:	❑ Active Military Duty ❑ Self-Employed ❑ Retired ❑ Unknown
State: Zip:	Employer Name:
Home Phone Number:	Student Status: ❑ Full-time ❑ Part-time ❑ Not a Student
❑ OK to leave a detailed message	**If you have an emergency or serious medical problem, who can we**
Cell Phone Number:	**contact?** *Please do not leave blank.*
❑ OK to leave a detailed message	Emergency Contact:
Work Phone Number:	Relationship:
❑ OK to leave a detailed message	Address:
Responsible Party:	City: State: Zip:
Relationship:	Phone:

INSURANCE/ FINANCIAL INFORMATION *(Please submit your insurance card(s) with this form for scanning.)*

Primary Insurance:		
Subscriber #:	Group #:	
Subscriber's Name:	Date of Birth:	Relation to patient:
Secondary Insurance:		
Subscriber #:	Group #:	
Subscriber's Name:	Date of Birth:	Relation to patient:

A secured Patient Portal to access your Personal Medical Records, request appointments, and communicate with us over the internet. ***(Your email address will not be shared with anyone outside Family Practice of Cadillac)***

Register for Patient Portal: ❑ Yes ❑ No Email address:

SURVEY INFORMATION

Race: ❑ White ❑ Black/ Af. American ❑ American Indian ❑ Alaskan Native ❑ Asian ❑ Pacific Islander/ Hawaiian Native ❑ Other

Are you Hispanic? ❑ Yes ❑ No | Preferred Language: ❑ English ❑ Other | Interpreter needed? ❑ Yes ❑ No

PHARMACY

Primary Pharmacy	
Name: Address:	
Phone:	Fax:
Secondary Pharmacy	
Name: Address:	
Phone:	Fax:

By signing below, I acknowledge that the information I provided is accurate to the best of my ability.

Patient Signature: Date: / /