PATIENT DEMOGRAPHIC SHEET

Thank you for completing this form, *our office assistant 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: θ Female θ Male
Previous Name:	Marital Status: θ Single θ Married θ Other_____
Mailing Address 1:	Spouse Name:
Street Address 2:	Employment Status: θ Full-time θ Part-time θ Not Employed
City:	θ Active Military Duty θ Self-Employed θ Retired θ Unknown
State: Zip:	Employer Name:
Home Phone Number:	Student Status: θ Full-time θ Part-time θ Not a Student
θ 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.*
θ OK to leave a detailed message θ OK to text to this number	Emergency Contact:
Work Phone Number:	Relationship:
θ 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: θ **Yes** θ **No** **Email address:**

SURVEY INFORMATION

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

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