

PATIENT DEMOGRAPHIC SHEET

PERSONAL INFORMATION		Today's Date: / /	
Last Name:		Date of Birth (mm/dd/yyyy):	
First Name:	Middle Initial:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender	
Mailing Address 1:		Marital Status:	
Address 2:		Social Security #:	
City:		Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Not Employed	
State:	Zip:	<input type="checkbox"/> Active Military Duty <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Student	
Home Phone: () <input type="checkbox"/> Preferred <input type="checkbox"/> Do not call <input type="checkbox"/> OK to leave message		Employer Name:	
Cell Phone: () <input type="checkbox"/> Preferred <input type="checkbox"/> Do not call <input type="checkbox"/> OK to leave message <input type="checkbox"/> Text Appt. Reminders		If you have an emergency or serious medical problem, who can we contact? <i>Please do not leave blank.</i>	
Work Phone: () <input type="checkbox"/> Preferred <input type="checkbox"/> Do not call <input type="checkbox"/> OK to leave message		Emergency Contact:	
		Relationship:	
		Address:	
		Phone: ()	

INSURANCE / FINANCIAL INFORMATION <i>(Please submit your insurance card(s) with this form for scanning.)</i>			
Primary Insurance:		Subscriber SS#:	
Subscriber #:		Group #:	
Subscriber's Name:		Date of Birth:	Relation to patient:
Secondary Insurance:		Subscriber SS#:	
Subscriber #:		Group #:	
Subscriber's Name:		Date of Birth:	Relation to patient:

We offer a secured Patient Portal to access your Personal Medical Records, request appointments, and communicate with our facilities over the internet. (Your email address will not be shared with anyone)
Register for Patient Portal: Yes No **Email Address:**

SURVEY INFORMATION			
Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Af. American <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander/Hawaiian Native <input type="checkbox"/> Other			
Are you Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No		Preferred Language: _____ Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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

OTHER PHYSICIANS			
Identification of other physicians involved with my medical care whom I authorize ongoing release of information for continuity of care:			
PRIMARY CARE PHYSICIAN			
Name:		Address:	Phone #:
REFERRING PHYSICIAN			
Name:		Address:	Phone #:

I hereby authorize my insurance benefits to be paid directly to Dayton Arthritis & Allergy Center, realizing I am responsible to pay non-covered services. I hereby authorize the release of pertinent medical information to my insurance plan.

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

Patient Signature: _____ **Date:** _____ / _____ / _____