PATIENT DEMOGRAPHIC SHEET

PERSONAL INFORMATION	Today's Date: / /

Last Name:	Date of Birth (mm/dd/yyyy):
First Name: Middle Initial:	Gender: ☐ Female ☐ Male ☐ Transgender
Mailing Address1:	Marital Status:
Address 2:	Social Security #:
City:	Employment Status: ☐ Full-time ☐ Part-time ☐ Not Employed ☐ Active Military Duty ☐ Disabled ☐ Retired ☐ Student
State: Zip:	Employer Name:
Home Phone: ( ) ☐ Preferred ☐ Do not call ☐ OK to leave message	If you have an emergency or serious medical problem, who can we contact? *Please do not leave blank.*
Cell Phone: ( ) ☐ Preferred ☐ Do not call ☐ OK to leave message ☐ Text Appt. Reminders	Emergency Contact:
Work Phone: ( ) ☐ Preferred ☐ Do not call ☐ OK to leave message	Relationship:
	Address:
	Phone: ( )

INSURANCE / FINANCIAL INFORMATION *(Please submit your insurance card(s) with this form for scanning.)*		
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: ☐ White ☐ Black/Af. American ☐ American Indian ☐ Alaskan Native ☐ Asian ☐ Pacific Islander/Hawaiian Native ☐ Other		
Are you Hispanic? ☐ Yes ☐ No	Preferred Language:	Interpreter needed? ☐ Yes ☐ 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:**_____/_____/_____