Demographic Data Sheet

Patient Information

First: ___________________ MI: ____ Last: _________________ Gender: Male/Female/Transgender

Date of Birth (MM/DD/YYYY):____ /____ /_____ Patient Social Security Number: ____ - ___ - _____

Home Phone: (____) ____ - _____ Cell Phone: (____) ____ - _____ Work Phone: (____) ____ - _____

Email Address: ____

Primary Care Provider (PCP): ______________________________ Date of Last Visit: ___ / ___ / ____

Preferred Patient Language: ______________________________ Interpreter Needed: YES or NO

Housing Situation (Check One):

- O At risk for homelessness
- O Currently not homeless, was in last 12 months
- O Homeless, unknown shelter
- O Living in shelter
- O Living with others
- O Not homeless
- O Street, Camp, Bridge
- O Transitional housing

Migrant/Seasonal:

- O Migrant
- O Neither
- O Seasonal

Ethnicity (Check One):

- O Hispanic
- O Non-Hispanic
- O Not Collected/Unknown
- O Prefer Not to Answer

Are you a Veteran? Yes or No

Race:

- O Alaskan Native
- O American Indian
- O Asian
- O African American/Black
- O Native Hawaiian
- O Unknown
- O Pacific Islander
- O Prefer Not to Answer
- O Caucasian/White

Income:

Number of people who live in your home: ____

Total Household Income:

____________ Monthly or Annual

Marital Status: Married/Divorced/Single

Are you legally disabled? Yes or No

Guarantor/Legal Guardian:

Name: ____

Address: ____

City: __________________________ **State:** __________________ **Zip:** ___________

Home Phone: (____) ____ - _____ **Cell Phone:** (____) ____ - _____ **Work Phone:** (____) ____ - _____

Email Address: _______________________________________ **Gender: Male/Female/Transgender**

Date of Birth (MM/DD/YYYY):____ /____ /_____ **Patient Social Security Number:** ____ - ___ - _____

Is patient address same as Guarantor address: Yes or No
Does the patient have insurance and/or Medicaid: Yes or No

Primary Insurance/Medicaid: ____

Subscriber Information: First: ____________________ **MI:** ____ **Last:** ____________________________

Subscriber Date of Birth: ____ /____ /____ **Subscriber Social Security Number:** ____ - ___ - ____

Employer: ____

Relationship to Patient: _______________________________

Subscriber ID: ____

Group Number: _______________________________________

Secondary Insurance/Medicaid: ____

Subscriber Information: First: ____________________ **MI:** ____ **Last:** ____________________________

Date of Birth (MM/DD/YYYY):____ /____ /_____

Patient Social Security Number: ____ - ___ - _____

Employer: ____

Relationship to Patient: _______________________________

Subscriber ID: ____

Group Number: _______________________________________