

PLEASE PRINT

Account # _____
(Office Use Only)

How were you referred to PHYSICIANS MEDICAL CENTER? _____

PATIENT DEMOGRAPHICS

Last Name _____ First Name _____

Address _____ Apt # _____ City & State _____ Zip _____

Dwelling: Home or Apartment (Please Circle One) Live Alone: Yes or No (Please Circle One)

Home Phone _____ Cell Phone _____ Work Phone _____

Date of Birth ____ / ____ / ____ Social Security # _____

Race (Please Circle One) Ethnicity (Please Circle One)

American Indian / Alaska Native / Asian / African American / More than one race Hispanic / Not Hispanic / Do not want to report

Native Hawaiian / Other Pacific Islander / Do not want to report / White

Age _____ Please check ___ Male ___ Female Marital Status _____

Place of Employment _____ Occupation _____

E-Mail Address _____

SPOUSE OR GUARANTOR

Last Name _____ First Name _____

Address _____ Apt # _____ City & State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Date of Birth ____ / ____ / ____ Social Security # _____

Place of Employment _____ Occupation _____

Guardian/Durable Power of Attorney ___ Yes ___ No If yes, name _____

Living Will ___ Yes ___ No Advance Direction ___ Yes ___ No

Nearest Relative Not Living With You: (Name, Address, Phone #, Relationship)

Whom May We Contact in Case of An Emergency? (Name, Address, Phone #, Relationship)

INSURANCE INFORMATION

Insurance Company _____

Address _____

Group # _____ Policy/Member/ID # _____

Relation to Insured ___ Self ___ Spouse ___ Child ___ Other

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information of both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify PHYSICIANS MEDICAL CENTER of any changes regarding my health status or the above information.

Signature _____ Date _____