Affix Patient Label

Patient Demographics

Demographics – Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

SSN: _____/_____/_____ Sex: M / F / U Birth Date: ____/____/____

Address: _____ Home Phone: _____

_____ Work Phone: _____

City: _____ Cell Phone: _____

State: _____ Zip: _____ E-Mail Address: _____

Other Communication

Allowed Communication: ____ Do Not Contact ____ Mail ____ Phone _____Text ____E –mail ____ MyChart Signup

Needs Interpreter? Y/ N Language: _____

Marital Status: _____ Religion: _____

Ethnicity: Hispanic/ Not Hispanic

Race: _____

PCP Care Provider Information

Primary Care Physician: _____

Emergency Contact – In Case of Emergency, who to contact

Last Name: _____ First Name: _____ Middle Name: _____

Relation to Patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient Employment

Employer: _____ Employment Status: _____ Not Employed

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Patient Name:_____ DOB:_____

Employer Address: _____ Employment date: _____

City: _____ Employee ID: _____

State: _____ Zip: _____ Occupation:_____

Phone: _____ Fax: _____

Religious Affiliation

Church: _____

Guarantor Accounts – If patient is over 18 years of age, see patient information

Last Name: _____ First Name: _____ Middle Name:_____

Account Type: Patient/Family / Workers Comp / Auto SSN: _____/_____/_____

Sex: M/F/U Birth Date: ____/____/____ Relation to Patient: _____

Address: _____ City: _____

_____ State: _____ Zip: _____

Home Phone: _____

Guarantor Employer: _____ Employ. Status: Full Time / Part Time

Address: _____ City: _____

_____ State: _____ Zip: _____

Phone: _____

Primary Coverage

Name of Coverage: _____

Member Relationship to Subscriber: _____

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Patient Name:_____ DOB:_____

Insurance ID: _____ Member Effective Date: _____

Group Number: _____ Group Name: _____

Authorization Phone: _____

Covered Through: Employment / Retirement Employer size: _____

Subscriber Name: _____ SSN: _____/_____/_____ Sex: M/ F / U

Birth Date: ____/____/____

Subscribers Address_____ City: _____

_____ State: _____ Zip: _____

Subscriber Phone: _____

Secondary Coverage

Name of Coverage: _____

Member Relationship to Subscriber: _____

Insurance ID: _____ Member Effective Date: _____

Group Number: _____ Group Name: _____

Authorization Phone: _____

Covered Through: Employment / Retirement Employer size: _____

Subscriber Name: _____ SSN: _____/_____/_____ Sex: M/ F / U

Birth Date: ____/____/____

Subscribers Address_____ City: _____

_____ State: _____ Zip: _____

Subscriber Phone: _____

Affix Patient Label

Patient Name:_____ DOB:_____

Visit Specific Information

Reason for Visit: _____

Accident Related: Y / N If Yes, Fill out Accident Information below

Accident Date: _____ Accident Time: _____

Accident Type: _____ Place of Injury: Home / Work / Other

Body Part Injured: _____ Accident Description: _____

_____

Referring Physician (if applicable):_____

MRN_____

CSN_____