

## Demographics

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

*Mailing/Secondary Address (if different from above):* \_\_\_\_\_

*City:* \_\_\_\_\_ *State:* \_\_\_\_\_ *Zip Code:* \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Gender: M or F

Family Doctor: \_\_\_\_\_ City, State: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_

Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

If you are not the primary insured then please complete the following:

Primary Insured's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Gender: M or F

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Patient Acknowledgment "I understand that I have the right to accept and refuse medical treatment and to exercise my right and implement an Advanced Directive." Advanced Directive" refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the following statements that apply:

- I Have Not executed an Advanced Directive
- I Have executed an Advanced Directive Location of Form: \_\_\_\_\_
- Living Will
- Durable Medical Power of Attorney
- Do Not Resuscitate (DNR) order
- Designation of health care surrogate form Designatee/Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_