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: _____

Rev 5/09