Health First
FAMILY MEDICINE

PATIENT DEMOGRAPHIC INFORMATION

Name _____ **Date** _____/_____/_____
Last First MI

DOB _____/_____/_____ **SSN** _____-_____-_____ **Age** _____ **Sex** ☐ **M** ☐ **F**

Address _____
Street Apt # City State Zip

Home Phone (_____)_____ **Cell Phone** (_____)_____ **Work Phone** (_____)_____
☐ Yes, messages can be left at this number ☐ Yes, messages can be left at this number ☐ Yes, messages can be left at this number

Which would you prefer we call? ☐ **Home** ☐ **Cell** ☐ **Work** **Email Address** _____

Preferred Pharmacy _____ **Pharmacy Crossroads & Phone** _____

Preferred Language ☐ **English** **Other** _____ **Race** _____

Marital Status _____ **Do you have an advance directive or living will?** ☐ **Yes** ☐ **No**

Emergency Contact _____
Name Phone Relationship

***If you would like to authorize Health First Family Medicine to release information regarding your medical care to someone in addition to yourself (spouse, parent, etc.) please list name below. If not, please check the box below and information regarding your healthcare will not be shared with anyone but yourself:**

_____ _____
Name **Relationship**

☐ **Please do not disclose information to anyone but myself**

INSURANCE POLICY HOLDER (IF DIFFERENT FROM PATIENT)

Print Name as it appears on your insurance card:

Name _____ **DOB** _____/_____/_____
Last First MI

Address _____
Street Apt # City State Zip

Contact Number (_____)_____ **Relationship to Patient** _____

Primary Insurance Information

Insurance Company _____ Benefit Phone _____

Subscriber ID # _____ Group # _____

Secondary Insurance Information

Insurance Company _____ Benefit Phone _____

Subscriber ID # _____ Group # _____

I have read all of the above information and have completed it to the best of my knowledge. I will notify you of any changes in my health status or demographic information. I hereby authorize Health First Family Medicine to furnish information to insurance carriers concerning my medical status. I understand that I am responsible for any amount not covered by my insurance.

_____ _____
Signature of Patient/Guardian **Date**