Patient Demographic Sheet

Admission Date	Admit Time	Registrar Initials		Social Security Number	Date of Birth

Patient Information **No Special Characters**

*Name (Last, First, Middle Initial)	*Sex	Race	Ethnicity	*Primary Language
	☐ Female ☐ Male	☐ Asian ☐ White ☐ Black ☐ Unknown ☐ Indian ☐ Pt. Declined	☐ Pt. Declined ☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ English ☐ Spanish ☐ Unknown
*Address	City, State, & Zip Code		*Phone	*Marital Status ☐ Divorced ☐ Married ☐ Life Partner ☐ Single ☐ Unknown ☐ Widowed ☐ Legally Separated

FACILITY USE ONLY

*Admission Type	*Admission Source		*HSV: _____
☐ Emergency ☐ Urgent ☒ Elective *Admission Status ☐ Involuntary ☒ Voluntary	☐ Non-Healthcare facility ☐ Transfer from Hospital ☐ Clinic or Physician office ☐ Transfer from SNF or ICF ☐ Court/Law Enforcement ☐ Info not available		*Accom Code: _____ *Room/Bed: _____/_____
*Admitting Doctor	*Attending Doctor	*Therapist information	*Diagnosis (ICD-10) _____
Dr. Bupp	Dr. Bupp		_____

Patients Employer Information

Employment Status	Employer Name	Phone Number
☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Unknown	Employer Address	Occupation/Job

Emergency Contact 1

*Name	*Address	*City / State / Zip

*Primary Phone Number	*Alternate Phone Number	*Relationship to Patient
(_____)	(_____) _____	

Emergency Contact 2

*Name	*Address	*City / State / Zip

*Primary Phone Number	*Alternate Phone Number	*Relationship to Patient
(_____)	(_____) _____	

Name of Person or agency who referred you to our facility?

Primary Insurance: **Subscriber {Check One}** ☐ **Patient** ☐ **Other – If "Other" complete subscriber information**

*Subscriber Name	*Date of Birth	*Pt's relationship to Subscriber	*Subscriber Social Security Number
	/ /		

*Subscriber Address	*City / State / Zip

*Insurance Company Name	*Insurance Company Address	*Insurance Company Phone Number
		(_____) _____

*Policy Number	*Group Number	*Authorization Number	*Employer Name

Do you have or have you had within the past 6 months any other health insurance? ☐ Yes or ☐ No

If yes, provide insurance carrier: Name: Policy #: Group #:

Have you notified your current insurance provider that you no longer have this previous coverage? ☐ Yes or ☐ No

Is your current insurance provider under the terms of Cobra? ☐ Yes or ☐ No

If yes, are your premium payments current? ☐ Yes or ☐ No Date coverage started:

Secondary Insurance: **Subscriber {Check One}** ☐ **Patient** ☐ **Other – If "Other" complete subscriber information**

*Subscriber Name	*Date of Birth ___/___/_____	*Pt's relationship to Subscriber	*Subscriber Social Security Number
*Subscriber Address		*City / State / Zip	
*Insurance Company Name	*Insurance Company Address	*Insurance Company Phone Number (_____) _____	
*Policy Number	*Group Number	*Authorization Number	*Employer Name
Notes / Comments			

Tertiary Insurance: **Subscriber {Check One}** ☐ **Patient** ☐ **Other – If "Other" complete subscriber information**

*Subscriber Name	*Date of Birth ___/___/_____	*Pt's relationship to Subscriber	*Subscriber Social Security Number
*Subscriber Address		*City / State / Zip	
*Insurance Company Name	*Insurance Company Address	*Insurance Company Phone Number (_____) _____	
*Policy Number	*Group Number	*Authorization Number	*Employer Name
Notes / Comments			

Guarantor Information: {*Check One*} ☐ **Patient** ☐ **Other – If "Other" complete Guarantor section**

*Relationship to Patient	*Name (Last, First, Middle Initial)	*Date of Birth ___/___/_____	*Gender ☐ Female ☐ Male
*Social Security Number	*Address	*City/State/Zip	

*Guar. Empl. Status ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Unknown	*Guarantor Employer Name	*Street Address	
	*City / State / Zip	*Employer Phone Number (_____) _____	*Occupation / Job

Pharmacy

*Name:	*Address
*Phone Number:	*Fax Number:

acknowledge that the information provided above is accurate and complete to the best of my knowledge.

Signature _____ Date_____