EXCELSIOR FAMILY MEDICINE

DEMOGRAPHIC FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

CONTACT INFORMATION

Preferred method for appointment reminders (Check all the apply): ❑ Text ❑ Email ❑ Voicemail ❑ No Reminders

Primary Phone Number: _____ Name: _____ Relation: _____

❑ Mobil ❑ Home ❑ Work Can we identify as Excelsior when we call? ❑ Yes ❑ No

Phone 2: _____ Name: _____ Relation: _____

❑ Mobil ❑ Home ❑ Work Can we identify as Excelsior when we call? ❑ Yes ❑ No

Phone 3: _____ Name: _____ Relation: _____

❑ Mobil ❑ Home ❑ Work Can we identify as Excelsior when we call? ❑ Yes ❑ No

Email 1: _____ Name: _____

Email 2: _____ Name: _____

PHYSICAL ADDRESS

OK to Mail? ❑ Yes ❑ No

Street Address: _____ Apt: _____

City: _____ County: _____ State: _____ Zip: _____

MAILING ADDRESS

❑ Same as Above OK to Mail? ❑ Yes ❑ No

Street Address: _____ Apt: _____

City: _____ County: _____ State: _____ Zip: _____

PATIENT INSURANCE INFORMATION

PRIMARY Insurance Company:

_____

Policy Holder Name: _____

Policy Holder DOB: _____

Policy Holder SSN: _____

Relationship to Patient: _____

Group Name: _____

Group No.: _____

Identification No: _____

Policy Holder Address: _____

Policy Holder Phone: _____

SECONDARY Insurance Company:

_____

Policy Holder Name: _____

Policy Holder DOB: _____

Policy Holder SSN: _____

Relationship to Patient: _____

Group Name: _____

Group No.: _____

Identification No: _____

Policy Holder Address: _____

Policy Holder Phone: _____

SERVICE PARTICIPANT DEMOGRAPHICS

Birth Gender:	❑ Female	❑ Male		
Gender Identity	❑ Female	❑ Male	❑ Genderqueer (neither exclusively male nor female)	
	❑ Transgender Female	❑ Transgender Male		
	❑ Intersex	❑ Questioning	❑ Unknown	❑ Do Not Want to Answer
Sexual Orientation:	❑ Straight	❑ Lesbian, Gay, Queer (Homosexual)	❑ Bisexual person	
	❑ Transexual	❑ Transitioning to Female	❑ Transitioning to Male	
	❑ Questioning	❑ Too young to ask (Under 13)	❑ Do Not Want to Answer	
Race:	❑ White/Caucasian	❑ Black/African American	❑ Asian	
(Check all that apply)	❑ Native Hawaiian	❑ American Indian or Alaska Native	❑ Other Pacific Islander	
	❑ Other: _____			
Ethnicity:	❑ Not of Hispanic Origin	❑ Hispanic or Latino		
Living Status:	❑ Private Residence (Children)	❑ Private Residence (Adults)		
	❑ Living Facility/Residential Care	❑ Crisis Residence		
	❑ Homeless with Housing	❑ Homeless without Housing		
	❑ Foster Home/Care	❑ Jail/Correctional Facility		
	❑ Dependent Living (Adults)	❑ Independent Living (Adults)		
	❑ Do Not Want to Answer	❑ Other Residential Status: _____		
Marital Status:	❑ Single/Never Married	❑ Married/Committed Relationship		
	❑ Separated	❑ Divorced	❑ Widowed	
Tobacco Use:	❑ Non-User	❑ User	What type of tobacco? _____	
		Frequency & Quantity of tobacco use: _____		
Smoking Status:	❑ Never Smoked	❑ Current Smoker	❑ Former Smoker	
Language:	Preferred Language: _____		Other Languages: ____	
	Do you need Interpreter Services? ❑ Yes ❑ No_____			
Military Status:	❑ Yes ❑ No	❑ Unknown	❑ Do Not Want to Answer	

EMPLOYMENT STATUS

❑ Employed PT	❑ Employed FT	❑ Unemployed	❑ Disabled	❑ Not in labor Force
❑ Student	❑ Homemaker	❑ Retired	❑ Volunteer	❑ Sheltered

Employer: _____ Job Title: _____ Days Worked Past 30 Days: _____