

PATIENT DEMOGRAPHIC INFORMATION

Last Name		First Name	
Middle Initial	Preferred/Nick Name	Social Security#	
Street—Apt/PO Box		Date of Birth	Gender
City	State	Zip	Email Address
Home Phone <input type="checkbox"/> Preferred Contact		Cell Phone <input type="checkbox"/> Preferred Contact	
Primary Care Doctor		Referring Doctor	
Employer Name		Employer Phone	
Emergency Contact Name		Emergency Contact Phone	

OPTIONAL SECTION: Race & Ethnicity questions are asked to identify additional care of our diverse patient population and are not used to discriminate.

Race <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White-Non Hispanic <input type="checkbox"/> Other/Multi-Racial	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to specify Preferred Language _____	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other	I Found Granite Peaks by: <input type="checkbox"/> Website <input type="checkbox"/> Facebook <input type="checkbox"/> Advertisement <input type="checkbox"/> Physician Referred <input type="checkbox"/> Fam/Friend Referral <input type="checkbox"/> Translation Needed
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MEDICAL INFORMATION ACCESS

May we leave a message at your preferred contact phone with **normal health results or information?** Yes No
I consent to receive automated text and email messages for general communications. You may opt out of this service, by writing us, at any time.

Please list any individual we are authorized to speak with regarding your protected **health information.**

Name	Relationship	Phone

Please list any individual we are authorized to speak with regarding your protected **financial information.**

Name	Relationship	Phone

RESPONSIBLE/FINANCIAL PARTY (IF OTHER THAN PATIENT)

Full Name	Date of Birth	Phone
Street	City/State/Zip	

PATIENT INSURANCE INFORMATION

PLEASE PROVIDE INSURANCE CARD(S) AND PHOTO ID TO RECEPTIONIST

Primary Insurance	Secondary Insurance
Subscriber's Name (If other than patient)	Subscriber's Name (If other than patient)
Relationship to Patient	Relationship to Patient
Subscriber's Date of Birth	Subscriber's Date of Birth

Patient Signature _____ **Date** _____