**PATIENT DEMOGRAPHICS** Woodrome Medical PA

**Name:**_____ **DOB:**____/____/____ **Chart Number:**_____

**Sex:** ☐ M ☐ F Marital Status: ☐ Single☐ Married☐ Widowed☐ Divorced **SS#**_____-_____-_____

**Email:**_____

**Address:**_____ **City:**_____ **State**____ **Zip**_____

**Home #:**_____ **Cell #:** _____ **Other #:**_____

**Occupation:**_____ **Employer:**_____ **Phone:**_____

**EMERGENCY CONTACT** **Name:**_____ **Phone #:**_____

**Ethnicity/Race:** ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American

☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Decline to answer

**Primary Language:** ☐ English ☐ Spanish ☐ ASL ☐ Other_____

**Privacy Information Preferences**

Have you completed any advanced directives? ☐ Y ☐ N Does anyone have Medical POA over you ☐ Y ☐ N

Do you want to exempt from public reporting? ☐ Y ☐ N Can we send mail to the address listed on file? ☐ Y ☐ N

Can we call the phone number on file? ☐ Y ☐ N Can we leave a voicemail on machine? ☐ Y ☐ N

Who can we leave messages with? ☐Spouse ☐ Parent ☐ Child ☐ Other_____ Name:_____

How did you hear about out office? ☐ Physician ☐ Website ☐ Phonebook ☐ Family ☐Friend ☐ Other _____

**Primary Insurance:**_____ **Are you the insured?**☐ Y ☐ N

**Member ID #:** _____ **Group #:**_____

**Relation to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other **Employer:**_____

**Subscriber Name:**_____ **DOB:**___/____/____ **Sex:** ☐ M ☐ F

**Address:**_____ **City:**_____ **State**_____ **Zip** _____

**Secondary Insurance:**_____ **Are you the insured?**☐ Y ☐ N

**Member ID #:** _____ **Group #:**_____

**Relation to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other **Employer:**_____

**Subscriber Name:**_____ **DOB:**___/____/____ **Sex:** ☐ M ☐ F

**Address:**_____ **City:**_____ **State**_____ **Zip**_____

***PLEASE READ AND SIGN***

*The information on my intake forms is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician/staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of information): I authorize the release of any medical information necessary to process the claim. (HIPPA Privacy): I acknowledge that I received my HIPPA Privacy Practices Notice. (Medication History): I Authorize the Doctors office to retrieve my medication history.*

Patient Signature: _____ Date: ____/_____/_____