



# St. Vincent Health

## PATIENT DEMOGRAPHIC INFORMATION FORM

PLEASE FILL OUT EVERY SPACE. IF IT DOES NOT PERTAIN TO YOU, PLEASE WRITE N/A, FOR NOT APPLICABLE.

### PATIENT INFORMATION (IDX screen 1)

<b>Patient's Name</b> (Last, First, Middle Initial)	<b>Sex</b> (Circle one)	<b>Birth Date</b>	<b>Social Security #</b>
AKA:	Male Female		
<b>Home Telephone #</b>	<b>Cell Phone #</b>	<b>Address</b> (Street, Apt.#, City, State)	<b>Zip Code</b>
<b>Marital Status</b> (Circle one) M S D W	<b>Ethnicity:</b>	<b>Race:</b>	<b>Primary Language Spoken:</b>
<b>Employment Status</b> (Circle one) Active Retired Other	<b>Name and Address of Patient's Employer</b>		<b>Work Telephone #</b>
Referral Information			
<b>Referring Provider:</b>		<b>PCP (Primary Care Provider):</b>	
<input type="checkbox"/> Friend/Family <input type="checkbox"/> Insurance <input type="checkbox"/> Internet <input type="checkbox"/> Phone Book <input type="checkbox"/> Advertisement <input type="checkbox"/> Other: _____			
<b>Email Address:</b>			
COMMUNICATION PREFERENCE			
<input type="checkbox"/> I authorize St. Vincent Physician Network, and those parties acting on behalf of St. Vincent Physician Network, to contact me to remind me to schedule appointments for health services.			
<b>I would like to receive such contact via:</b> <input type="checkbox"/> E-mail <input type="checkbox"/> Text Message <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> I do not want appointment reminders			
<b>ICC - How may we contact you?</b> (please check ALL that apply) <input type="checkbox"/> E-mail <input type="checkbox"/> Text Message <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> US Mail			
<b>Is it ok to leave medical information on your answering machine or voicemail?</b> Yes      No      (initials)			

### GUARANTOR (IDX screen 2)   Check if information is the same as above.

<b>Name of Person Responsible for the Bill</b> (Last, First, Middle Initial)	<b>Relationship to Patient</b> (circle one)		
	Self	Spouse	Parent/Guardian   Other
<b>Address</b> (Street, Apt.#, City, State)	<b>Zip Code</b>	<b>Home Tel:</b>	
<b>Social Security #</b>	<b>Date of Birth:</b>		
<b>Sex</b> (Circle one)	<b>Marital Status</b> (Circle one)		
Male   Female	M S D W		
<b>Name and Address of Employer</b>		<b>Work Telephone:</b>	

### Emergency Contact Information (IDX screen 3)

<b>Name:</b>	<b>Relationship to Patient:</b> Spouse   Parent   Child   Other _____		
<b>Home Telephone #</b>	<b>Work Telephone #</b>	<b>Cell Phone #</b>	
<b>Do you have an Advance Directive on file?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			

### Additional Registration Notes (IDX screen 4)

(such as Mother/Father info for minor child if different from primary information, legal guardian, power of attorney, etc.)
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