DORAN CLINIC for Women

Chart#_____

# PATIENT DEMOGRAPHIC FORM

Please complete this form in order to ensure proper billing of your services.

## PATIENT INFORMATION

Today's Date:_____

Last Name: _____ First Name: _____ Middle Initial: _____

Other Name: _____ Date of Birth: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Family Physician: _____ Ref. Physician (if different): _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Telephone #: _____ Telephone #: _____

Sex: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑ Partner

## EMPLOYMENT INFORMATION

Employer: _____

Emp. Status: ❑ Full Time ❑ Part Time ❑ Not Employed ❑ Self-Employed ❑ Active Military

Student Status: ❑ Full Time ❑ Part Time

Student's Permanent Address: _____

City: _____ State: _____ Zip: _____

## INSURANCE INFORMATION

PRIMARY CARRIER: _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Policy Holder's Phone #: _____

Policy #: _____ Group #: _____ Effective Date: _____

SECONDARY CARRIER: _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Policy Holder's Phone #: _____

Policy #: _____ Group #: _____ Effective Date: _____

## EMERGENCY CONTACT INFORMATION

Contact: _____ Relationship to You: _____

Home Phone: _____ Alt. Phone: _____

Contact: _____ Relationship to You: _____

Home Phone: _____ Alt. Phone: _____

## ELECTRONIC COMMUNICATIONS

**Automated Calls:** As an added convenience, we offer automated appointment reminders via a text message or an automated call for those who want to participate. The reminders are sent from a computer and cannot be used as a way for you to communicate back to us. If you should need to reach us, please call our main number. If at any time you should change your mind, please let us know what other method you would prefer for appointment reminders.

I understand under the telephone consumer protection act, that in order for you to contact me by automated means for services relating to my medical care, including monies I may owe, etc., I agree that Doran Clinic For Women and/or your agents may contact me by my cell phone, which may result in charges to me. You may also contact me by text messages, or emails providing that I have consented above. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automated dialing device, as applicable.

❑ Yes, I want to participate, my cell number is provided below.

Cell Phone Number: _____

❑ No, I do not wish to participate at this time.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

## ADDITIONAL INFORMATION

**Race:** Which category best describes your racial background?

❑ American Indian or Alaska Native
❑ Asian
❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander
❑ White
❑ Unreported/Refused to Report

**Ethnicity:** How would you describe your ethnicity, such as your family background or ancestry?

❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unreported/Refused to Report

**Preferred Language:** What language do you usually speak at home?

❑ English ❑ Spanish ❑ Other _____

How did you hear about our practice? ❑ Health Plan ❑ Internet ❑ Our Web Site ❑ ER/Hospital
❑ Newspaper/Magazine ❑ Patient _____ ❑ Other _____

## PHARMACY INFORMATION

**Pharmacy Name:** _____ ❑ **Local** ❑ **Mail away**

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

**Phone:** _____ **Fax:** _____

**Pharmacy Name:** _____ ❑ **Local** ❑ **Mail away**

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

**Phone:** _____ **Fax:** _____

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

Doran Clinic For Women complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-515-239-6972.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-515-239-6972。