Dignity Health.

Adult Demographics

PATIENT INFORMATION

Last Name		First Name	Middle
Social Security Number	Date of Birth	Legal Gender ☐ Male ☐ Female ☐ Nonbinary	Marital Status
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Other ☐ Decline to Answer			
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to state		Language	Preferred Language for Health Care Information
Mailing Address		City	State / Zip
Primary Contact Number ☐ Home ☐ Cell ☐ Work ( )	Secondary Contact Number ☐ Home ☐ Cell ☐ Work ( )	Preferred Notify Method: ☐ Home ☐ Cell ☐ Work Other: ( )	
E-Mail Address		Employer	
Emergency Contact:		Relationship to patient	Emergency Contact Number:

RESPONSIBLE PARTY'S INFORMATION (IF OTHER THAN PATIENT)

Last Name	First Name	Middle	Relationship to Patient
Date of Birth		Primary Contact Number ☐ Home ☐ Cell ☐ Work ( )	
Mailing Address		City	State / Zip

FAMILY AND FRIENDS ACCESS (OPTIONAL)

☐ I do NOT permit Dignity Health to share my appointment date/time, and/or billing with any individuals aside from myself.
☐ I do permit Dignity Health to share my appointment date/time, and/or billing with any individuals listed below:

Full Name:	Full Name:	Full Name:
Relationship to Patient:	Relationship to Patient:	Relationship to Patient:

INSURANCE INFORMATION

Primary Insurance Carrier	Worker's Comp Injury ☐ Yes ☐ No	Insurance Billing Address:	
Policy/Group Number:	Subscriber Full Name:		Subscriber Date of Birth:
Secondary Insurance Carrier		Insurance Billing Address:	
Policy/Group Number:	Subscriber Full Name:		Subscriber Date of Birth: