FAMILY MEDICINE CLINIC AND CAMPUS HEALTH CENTER
PATIENT DEMOGRAPHIC SHEET

PATIENT INFORMATION:

Name: _____
Last First Preferred Middle

Former Last Name: _____ Sex: ____DOB: _____ Social Security #: ____-____-_____

Mailing Address: _____

Zip: _____ City: _____ State: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Consent to Text: ☐ Yes ☐ No Work Phone: (____) _____ Extension: _____

Consent to Call: ☐ Yes ☐ No Medication History Authority: ☐ Yes ☐ No

Please note: by declining consent to receive calls you will not receive communication reminding you of your appointment.

PATIENT PORTAL

Your patient portal is a a convenient tool to help you access your health records and information about your treatment, including lab test results, medications, refill requests, summary of care, online bill pay, and more. You can also communicate online with your provider and nursing staff.

Patient Email: _____

☐ Consent to portal access ☐ Decline portal access ☐ I do not care to provide my email

By receiving email for the patient portal, you consent to be contacted for our patient satisfaction survey

Contact Preference: ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Mail ☐ Portal

Language: _____ Race: _____ Ethnicity: _____

Marital Status: _____ How did you hear about us? _____

Preferred Pharmacy: _____ Primary Care Provider: _____

How would you prefer to access you patient care summary? ☐ Portal ☐ Paper Copy

GUARDIAN (If patient is under 18)

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

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Home Phone: _____ Mobile Phone: _____

NEXT OF KIN

Name: _____ Relationship to Patient: _____ Phone: _____

Updated 2/2/17

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EMPLOYMENT

Employer Name: _____ Employer Phone: _____

Occupation (current or most recent): _____

Employer Address: _____

Zip: _____ City: _____ State: _____

GUARANTOR (Insurance Policy Holder) **INFORMATION:**

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

DOB: _____ Patient's Relationship to Guarantor: _____

Policy Holder's Address: _____

City: _____ State: _____ Zip: _____

PRIMARY INSURANCE INFORMATION
Please present a copy of your insurance card when providing this form to registration

Insurance Carrier: _____ Policy Number: _____

Group Number: _____ Policy Holder: _____

Relationship to Patient: _____ Phone Number: (____) _____

Policy Holder DOB: _____

Policy Holder's Address: _____

City: _____ State: _____ Zip: _____

☐ No Insurance (ask our receptionist about financial addistance through Gunnison Valley Health) ☐ Self-pay

SECONDARY INSURANCE INFORMATION (If applicable)
Please present a copy of your insurance card when providing this form to registration

Insurance Carrier: _____ Policy Number: _____

Group Number: _____ Policy Holder: _____

Relationship to Patient: _____ Phone Number: (____) _____

Policy Holder DOB: _____

Policy Holder's Address: _____

City: _____ State: _____ Zip: _____

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Driver's License Number: _____ State: _____ Expiration: _____
Please provide us with your Driver's License so we can make a copy for our files

I agree that this form is complete and correct

_____

Print Name Signature Date

OFFICE USE ONLY

Gunnison Valley Health Conditions of Service Sign On: _____