Patient Demographic Information

Name (Last): _____ (First): _____ (MI): _____

Preferred Name:_____ Former/Maiden Name:_____

Date of Birth: _____/__ _____/_____ SSN: _____-_____-_____ Sex: ☐Male ☐Female

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Number: _____ Cell Number: _____

Work Number: _____ Preferred: ☐Home ☐Cell ☐Work

Email: _____

Race: ☐White ☐Black/AA ☐Asian ☐Hawaiian/Pacific Islander ☐American/Alaskan Indian
☐Hispanic or Latino ☐Unknown ☐Decline to specify ☐Other: _____

Ethnicity: ☐Not Hispanic/Latino ☐Hispanic/Latino ☐Unknown ☐Decline to specify ☐Other: _____

Employment Status: ☐Employed ☐Unemployed ☐Student ☐Retired ☐Other: _____

Employer: _____

Primary Care Provider: _____

Practice Name / Location: _____

Referring Provider / Person: _____

Preferred Pharmacy: _____ Phone: _____

Pharmacy Location: _____

Emergency Contact / HIPAA Authorization

Name: _____

Phone: _____ Relationship: _____

☐ I consent to the person named above to be contacted regarding an emergency situation

☐ I consent to the person named above to be provided applicable protected health information regarding my routine care and/or health emergency status.

_____ I consent to receive phone communications, email and text notifications from SCVH and their business assoc.
Please initial

I consent to potentially receive medical/health information from this practice in the following methods:
Please Initial:

_____ ☐Mail at address listed above
_____ ☐Preferred phone call / message with office contact name and number only
_____ ☐Preferred phone call with detailed message
_____ ☐Other: _____

Signature: _____ Date: _____

10/2022