Patient Demographics

LITTLE RIVER HEALTHCARE

Patient Information

Name (Last, First, MI) ____________________ Age: ________ Driver's License #: ____________________

Address: ____________________ City/State/Zip: ____________________

Home Phone #: ____________________ Cell Phone #: ____________________ Social Security #: ____________________

Date of Birth: ____ / ____ / ______ Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Referring Provider: ____________________ Referrer's Phone #: ____________________ Pharmacy: ____________________

Advanced Directive: ☐ Yes ☐ No ☐ I would like information about advanced directives; Organ Donor: ☐ Yes ☐ No

Is this visit the result of an accident? ☐ Yes ☐ No ☐ Other: ____________________

Patient's Employer: ____________________ Occupation: ____________________

Address: ____________________ City/State/Zip: ____________________

Work Phone #: ____________________ E-Mail Address: ____________________

Guarantor Information

Responsible Party: ____________________ Social Security #: ____________________ Relationship: ____________________

Date of Birth: ____ / ____ / ______ Address: ____________________ City/State/Zip:____________________

Home Phone #: ____________________ Cell Phone #: ____________________ Work Phone #: ____________________

Guarantor's Employer: ____________________ City/State/Zip: ____________________

Emergency Contact Information

Nearest Relative: ____________________ Relationship: ____________________Home Phone #: ____________________

Employer: ____________________ Work Phone #:____________________

Notify in Case of Emergency: ____________________ Relationship: ____________________

Address: ____________________ City/State/Zip: ____________________ Phone #: ____________________

Financial / Insurance Information

MUST PRESENT INSURANCE CARD/FORMS, DRIVER'S LICENSE AND SOCIAL SECURITY CARD

METHOD OF PAYMENT: ☐ Cash ☐ Worker's Comp ☐ Commercial Insurance ☐ Medicare ☐ Medicaid

Primary Insurance Carrier: ____________________ Type of Insurance: ☐ HMO ☐ PPO ☐ POS ☐ Other

Policy #: ____________________ Group Name/ Group #: ____________________ Effective Date: ____ / ____ / _______

Employer: ____________________ Policy Holder Name: ____________________

Policy Holder Date of Birth: ____ / ____ / ______ Policy Holder's Social Security #: ____________________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: ____________________

Patient Signature: ____________________

Date: _____ / _____ / _________

LITTLE RIVER HEALTHCARE

www.LRhealthcare.com