PHI Annual Demographic Information Form

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

Patient Name	Preferred Name	SSN #	Date of Birth	Age	Sex
Home Address	City	State	Zip	Primary Phone #	
Mailing Address	City	State	Zip	Secondary Phone #	
Occupation	Employer's Name or if Student, Name of School			E-mail	
Patient's Family Physician (Doctor's Name, not Group)		Referred by?			

I authorize pathology reports to be sent to the family physician and/or referring physician listed above: YES / NO

Parent/Guardian Information for Minors (under 18 years old)

Parent/Guardian of Patient	S.S. #	Date of Birth	Relation to Patient
Billing Address (if different than above)	City	State	Zip
Primary Phone (if different than above)	Secondary Phone	Work Phone	E-mail
Occupation	Employer		

Emergency Contact

Name	Relationship	Primary Phone	Secondary Phone
Address	City	State	Zip

Medical Insurance Subscriber Information – COMPLETE IF SUBSCRIBER IS NOT THE PATIENT

PRIMARY Insurance Policy	Name as it Appears on Card	Relation to Patient
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#
SECONDARY Insurance Policy	Name as it Appears on Card	Relation to Patient
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#

Do We Have Your Permission To:

Leave a message on your voice mail?	YES / NO
Attempt to reach you at your place of employment?	YES / NO
Leave a message at your place of employment?	YES / NO

Person(s) we can discuss your medical condition with:

Name: _____ Relation: _____

Name: _____ Relation: _____

☐ Check here if the person is the same as the emergency contact.