CenterWell

Patient Demographic Form

Please complete the below information so that we can better service your needs.

Patient Information

Patient Name: ______________________ ____________ ______________________
Last Name MI First Name

Mailing Address: ______________________ Bldg. No. ________ Apt. No ________

City: ______________ State: ______________ Zip: ____________

Date Of Birth: ______________________ Marital Status: ______________________

Home Phone: ______________ Cell: ______________ Work: ______________

Email address: ____

Gender Identity: What sex were you **assigned at birth,** on your original birth certificate?

☐ Male ☐ Female

Is there anything about your identity that you would want your provider to know?

____

____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ White ☐ Other Race

☐ Prefer not to disclose

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to disclose

Primary Language: ☐ English ☐ Spanish ☐ Creole ☐ Other: ______________

Preferred Pharmacy: ____

Address: ____

City: ______________ State: ______________ Zip: ____________

Phone Number: ______________________ Fax number: ______________________

Advanced Directive:

Do you have an Advanced Directive? ☐ Yes ☐ No

Do you have a Surrogate if yes provide their name? ☐ Yes ☐ No

Surrogate's Name: ____

CenterWell

Patient Demographic Form

Patient Name: ______________________________ DOB: ________

Resident Type

☐ Private Home (Spouse) ☐ Private Home (Family Member)

☐ Independent/Assisted Living ☐ Nursing Home

Emergency Contact:

Emergency Contact Name: ____________________ Phone Number: ______________

Relationship ____

Reminder Preferences

Would you like to receive reminders?

☐ Yes, I would like to receive reminders for appointments and general health reminders (i.e. annual flu shot).

Contact Preferences:

What is the preferred number to call:	☐ Home	☐ Cell	☐ Work
What is the preferred method?	☐ Voice (Call)	☐ Text (SMS) (Data Charges may apply)	
What is the preferred time:	☐ Mornings	☐ Afternoons	☐ Evenings

☐ No, please do not send me reminders.

Patient Name Signature and Date