HOLY REDEEMER PHYSICIAN SERVICES

PATIENT INFORMATION PLEASE PRINT

Patient Name: _____

Previous Name: _____

Address: _____
City, State: _____
Zip: _____

Home Phone: _____
Cell: _____
Work Phone: _____

Responsible Party: **Self _____ OR**
Name: _____
Address: _____
City: _____
Relationship: _____ DOB: _____

Policy Holder/Subscriber:
Self _____ OR
Name: _____
DOB: _____ SS#: _____
Address: _____
_____
Phone: _____

Primary Insurance:
Company: _____
Address: _____
City/State: _____ Zip: _____
Phone: _____
ID# _____
Group# _____

Primary Care Physician:
_____
Address: _____
_____
Phone: _____
Fax: _____

Name of Doctor who referred you:
_____
(If applicable)

Patient DOB_____

Gender:
Male _____ Female _____
Transgender _____
Patient declines to provide: _____

Social Security:_____

Employer Name: _____
Address: _____
Phone: _____

Emergency Contact:
Name: _____
Address: _____
Phone: _____
Relationship: _____

Secondary Insurance:
Company: _____
Address: _____
City/State: _____ Zip: _____
Phone: _____
ID# _____
Group# _____

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PATIENT INFORMATION PLEASE PRINT

Patient Name: _____ DOB: _____

*Email address: Enter Email address below or, ☐ I do not have an email address

_____

Permission to leave message:
(*check all that are permitted*)
At Home: ___ Cell ___ Work ____

*Race: *Check one that describes your race*

American Indian_____ Alaska Native _____ Asian _____

Black or African American _____

Native Hawaiian or Other Pacific Islander _____ White _____

Patient declines to provide: _____

*Ethnicity: *Check one*:

Hispanic or Latino _____ Not Hispanic or Latino _____
Patient declines to provide: _____

*Language: English _____ Other: _____
Patient declines to provide: _____

Note: items are for information being requested by the Government for reporting purposes.

Local Pharmacy:
Name: _____
Address: _____
City/State: _____
Phone: _____
Fax: _____

Mail-In Pharmacy:
Name: _____
Address: _____
City/State: _____
Phone: _____
Fax: _____

I verify that my demographic information is correct by my signature below.

Signature: Date:

_____ _____