

# Pinchot Family Medicine, P.C. Patient Demographics Sheet

## Patient Information

**Name** \_\_\_\_\_  
First Name Middle Name Last Name

Sex  F  M Date of Birth \_\_\_\_\_ Race \_\_\_\_\_ Marital Status  M  S  
 D  W

E-Mail \_\_\_\_\_ SSAN \_\_\_\_\_

**Address** \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  Employed  
 Spouse or Guardian \_\_\_\_\_  Full-Time Student  
Name First name Last Name  Part Time Student  
 Active Military  
 In-Active Military

Do we have permission to Email you results?  Y  N  
 How did you hear about us? \_\_\_\_\_

## Emergency Point of Contact

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Phone \_\_\_\_\_

## Employer Information

Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Work Address \_\_\_\_\_  
Street City State Zip  
 Main Work Phone \_\_\_\_\_ Main Work FAX \_\_\_\_\_

## Insurance

Are you:  Self-Insured  Under Another's Policy  Self Pay  
If under another party, fill in their subscriber information below:

Subscriber _____ <small>(Name of Insured First Middle Last)</small>	Subscriber SSAN _____
Relationship _____	Sex <input type="checkbox"/> F <input type="checkbox"/> M Date of Birth _____
ID Number _____	Employer _____
Group Number _____	Deductable _____
Plan _____	Co-Pay _____ Co-Insurance _____

### Secondary Insurance

Subscriber _____ <small>(Name of Insured First Middle Last)</small>	Subscriber SSAN _____
ID Number _____	Employer _____
Group Number _____	Deductable _____
Plan _____	Co-Pay _____ Co-Insurance _____

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_