Family Care Network
*We Take Care*

# PATIENT DEMOGRAPHIC FORM

## PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Previous Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Sex: ❑ Male ❑ Female Marital Status: _____

Employer: _____ Occupation: _____

Emergency Contact #1:

Name: _____

Phone: _____

Relationship: _____

Emergency Contact #2:

Name: _____

Phone: _____

Relationship: _____

## INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID #: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____ Relationship: _____

Subscriber Employer: _____

SECONDARY INSURANCE: _____ ID #: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____ Relationship: _____

Subscriber Employer: _____

ADDITIONAL INSURANCE: _____ (Bring insurance card to your appointment)

If Secondary or Additional insurance is Medicare, please fill out the Medicare Coordination of Benefits Questionnaire.

## GUARANTOR INFORMATION

(Person responsible for charges)

Complete this section for patients under age 18. All patients age 18 and older are their own guarantor, with limited exceptions.

Name: _____ Relationship to You: _____

Address: _____ Date of birth: _____

Employer: _____ Phone: _____

## AUTHORIZATION TO BILL

I verify that this address, phone number, guarantor, and insurance is correct. I authorize my insurance benefits be paid directly to the health care provider. I am financially responsible for any balance due. I also authorize the health care provider or insurance company to release any information required for this claim. MEDICARE: I understand my provider agrees to accept the Medicare allowed charge as the full charge, and I am only responsible for the deductible, co-insurance and non-covered services.

Signature: _____ Date: _____

*Patient or legally authorized individual signature. Signature required for FCN to bill insurance.*

Print Name: _____

*Printed name of person signing form.*

***Continued on back.***

## ELECTRONIC COMMUNICATIONS

**Portal:** We offer secure electronic communications between you and our office via our InTouch® Patient Portal. Secure messages and information can only be read by someone who knows the right password to login to the portal site. The communications are secure and for those who want to participate, this can be a valuable and convenient tool to provide administrative and clinical information.

❑ Yes, I want to participate. Email (for portal invitation): _____

❑ No, I do not wish to participate at this time.

SIGNATURE OF PATIENT OR REPRESENTATIVE _____ DATE _____

## ETHNICITY, RACE & LANGUAGE

We participate in federal and state programs that ask us to collect this information, for civil rights compliance reporting and state-supplied vaccines.

**Ethnicity:** Please check one.

| | | |
|---|---|---|
| ❑ | Hispanic/Latino | A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. |
| ❑ | Non-Hispanic/Latino | All other cultural heritages. |
| ❑ | I would prefer not to answer. | |

**Race:** Check all that apply.

| | | |
|---|---|---|
| ❑ | American Indian/Alaskan Native | A person having origins in any of the original peoples of North, Central or South America, and who maintains tribal affiliation or community attachment. |
| ❑ | Asian | A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. |
| ❑ | Black, Haitian or African American | A person having origins in any of the black racial groups of Africa. |
| ❑ | Hispanic or Latino | A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin. |
| ❑ | Native Hawaiian or Other Pacific Islander | A person having origins in any of the original peoples of Hawaii, Guan, Samoa, or other Pacific Islands. |
| ❑ | White | A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. |
| ❑ | I would prefer not to answer. | |

**Language:** Please check your preferred communication language.

| | | | |
|---|---|---|---|
| ❑ English | ❑ Spanish | ❑ Russian | ❑ Arabic |
| ❑ Bosnian | ❑ Cantonese | ❑ Farsi | ❑ Filipino (Tagalog) |
| ❑ French | ❑ German | ❑ Italian | ❑ Japanese |
| ❑ Korean | ❑ Mandarin | ❑ Portuguese | ❑ Punjabi |
| ❑ Serbian | ❑ Sign Language | ❑ Slovak | ❑ Somali |
| ❑ Thai | ❑ Ukrainian | ❑ Urdu | ❑ Vietnamese |
| ❑ Other: | | | |
| ❑ I would prefer not to answer. | | | |