

PHOENIX FAMILY CENTER, LLC

DEMOGRAPHIC FORM

PATIENT INFORMATION

Title Name	First	M.I.	Last		
Address		City	State	Zip	County
Home Phone	Work Phone	Cell Phone	SS #		
Birthdate	Age	Sex (circle one) M F	Marital Status	Spouse's Name	
Patient Employer		Driver's License #			
Address		City	State	Zip	
Preferred Language: _____		Race: White African American Asian Native American Pacific Islander other			
Ethnicity: Latino other					
Interpreter needed? _____					
Preferred Communication Method: Phone Letter E-mail					
E-mail address (if preferred)					

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Name/ First	M.I.	Last		
Address		City	State	Zip

Home Phone	Work Phone	SS #			
Employer	Address		City	State	Zip

INSURANCE INFORMATION

Primary Insurance Company		Insured's Name			Employer	
Address		City	State	Zip	Phone#	
Relationship to Patient	SS #	Group #		* Birthdate		
Secondary Insurance Company		Insured's Name			Employer	
Address		City	State	Zip	Phone #	
Relationship to Patient	SS #	Group #		*Birthdate		

FAMILY MEMBER INFORMATION

First	Last	M/ F	Relation	DOB	School/Work
Name/Phone Number of individual to be contacted in case of an Emergency:					
Referred By:			Primary Care Physician:		

In order for us provide accurate and essential care for you, please fill out the following:

REQUIRED INFORMATION		
Pharmacy Name:	Street:	City:
Allergies:		
Smoking: please circle	Current - every day smoker Former smoker	Current - some days Never a smoker

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)

PRIOR ATTEMPTS TO CORRECT PROBLEMS

(Please include contact with other professionals, therapist, psychiatrists, etc.)

SCHOOL HISTORY: Highest grade completed ____ Last school attended _____

(Check the correct answer)

CURRENTLY EMPLOYED: Yes _____ No _____

CURRENTLY RECEIVING SOCIAL SECURITY: SSI _____ SSDI _____

HAVE YOU EVER BEEN DENIED SOCIAL SECURITY: Yes _____ No _____

MILITARY: Doesn't Apply _____ Active Duty _____ Veteran _____

CITIZENSHIP: U.S. Citizen Yes _____ U.S. Citizen No _____

COURT INVOLVEMENT: Doesn't Apply _____ Arrested _____ Charged with a Crime _____ Probation _____ Parole _____ Other _____

RESIDENTIAL ARRANGEMENT: Homeless _____ Private Residence _____ State Operated Facility _____ Nursing Home _____ Other _____

Medication Log

Medication Prescribed	Directions	Prescribing Doctor