Gastroenterology Associates

Gastroenterology and Hepatology
olygastro.com

PATIENT DEMOGRAPHIC FORM

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Address: _____ **City/State:** _____ **Zip:** _____

Mobile Phone: _____ **Home Number:** _____

Marital Status: ⬭ Married ⬭ Single ⬭ Divorced ⬭ Widowed ⬭ Other: _____

Pharmacy: _____ **Primary Care Physician:** _____
Name City

Gender

⬭ Male ⬭ Female ⬭ Transgender Male/Trans Man/Female to Male ⬭ Transgender Female/Trans Woman/Male to Female

⬭ Genderqueer/Neither Exclusively Male nor Female ⬭ Other, Please Specify _____ ⬭ Chooses Not to Disclose

Preferred Language

⬭ English ⬭ Spanish ⬭ Korean ⬭ Vietnamese ⬭ Other: _____

Race

⬭ White/Caucasian ⬭ Black or African American ⬭ Asian ⬭ American Indian or Alaska Native ⬭ Native Hawaiian or Pacific Islander

⬭ Other Race ⬭ Unknown ⬭ Patient declines to specify ⬭ Prohibited by state law

Ethnicity

⬭ Hispanic or Latino ⬭ Not Hispanic or Latino ⬭ Patient declines ⬭ Prohibited by state law ⬭ Unknown

Employment

⬭ Employed ⬭ Retired ⬭ Unemployed ⬭ Other: _____ **Occupation:** _____
Employer: _____ **Employer Phone:** _____

Do you currently live in a congregate care facility? ⬭ No ⬭ Yes, select type of facility below

⬭ Nursing/ Rehabilitation/ Assisted Living Facility, Name: _____ ⬭ Dept. of Corrections

Primary Insurance

Insurance Name: _____ ID #: _____ Group #: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Subscriber's Employer: _____ Subscriber's Phone Number: _____

Secondary Insurance

Insurance Name: _____ ID #: _____ Group #: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Subscriber's Employer: _____ Subscriber's Phone Number: _____

Signature **Date**