New Patient Demographics

Singing River Health System

Patient's Legal Name: _____ Patient's SSN: ____ - ____ - ____

Sex: ☐ Male ☐ Female Birthday: ____ / ____ / ____ Preferred Name: _____

Address: _____

Street Address City State Zip Code

Mailing Address (if different from street Address) _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Home # ( ) - _____ Work #: ( ) - _____ Cell#: ( ) - _____

Email Address: _____

Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

Spouses Name: _____ Spouse's Employer: _____ Spouse's SSN: ____ - ____ - ____

Primary Insurance: _____ Policy #: _____

Group#: _____ Relationship to subscriber: _____

Subscriber: _____ SSN#: _____ DOB: _____

Secondary Insurance: _____ Policy #: _____

Group#: _____ Relationship to subscriber: _____

Subscriber: _____ SSN#: _____ DOB: _____

Person responsible for payment (Guarantor): _____

Emergency Contact: _____ Relationship to Patient: _____ Phone: _____

Emergency Contact: _____ Relationship to Patient: _____ Phone: _____

The above emergency contacts can receive the following information:

☐ Appointment Time ☐ Test/Lab Results ☐ Medication ☐ Procedure ☐ Other information regarding his/her health

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The parent or legal guardian must complete this section if the patient is under the age of eighteen (18) years of age

Parent or Legal Guardian Name: _____ SSN: ____ - ____ - ____

Parent or Legal Guardian DOB: _____ Place of Employment: _____

Patient's Primary Language (if other than English): ☐ **Spanish** ☐ **Vietnamese** ☐ **ASL** ☐ **Other** _____

_____ _____ _____

Printed Name of Interpreter Signature of Interpreter Date

_____ _____

Signature of Patient or Legal Representative *Date*