ANMED HEALTH
PATIENT DEMOGRAPHICS

IMPORTANT NOTICE

Due to HIPAA requirements, this form must be filled out completely.
Please ask for help if you have questions about any field.
We will be unable to file insurance for incomplete forms. Thank You.

PATIENT INFORMATION:

Full Name:		Social Security #:	
Date of Birth:		Name you wish to be called:	

Legal Sex: (as on your driver's license)
M F

Gender Identity:
☐ Female ☐ Male ☐ Choose not to disclose ☐ Transgender Female (male-to-female) ☐ Transgender Male (female-to-male) ☐ Other

Sex at Birth:
☐ Female ☐ Male ☐ Choose not to disclose ☐ Unknown ☐ Uncertain ☐ Not recorded on birth certificate

Sexual Orientation:
☐ Straight ☐ Lesbian or Gay ☐ Choose not to disclose ☐ Bisexual ☐ Don't Know ☐ Something else

Mailing Address:			
City, State, Zip:		County:	
Street Address:			
City, State, Zip:		County:	
Home Phone #:	Work Phone #:	Mobile #:	
Email Address:	I DON'T HAVE EMAIL NO THANKS		

What is your preference of contact for appointment reminders? TEXT EMAIL PHONE

Marital Status:
☐ Divorced ☐ Legally Separated ☐ Married ☐ Significant Other ☐ Single ☐ Widowed ☐ Other ☐ Unknown

Do you need an Interpreter?
YES NO

Language Preference:

Written Language Preference:

Religion:

Race (choose one):
☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American ☐ Hispanic ☐ Native Hawaiian / Other Pacific Islander ☐ White ☐ Two or more races ☐ Declined ☐ Unknown

Ethnicity (where were you born?):
☐ USA ☐ Not Hispanic, Latino/a or Spanish origin ☐ Colombian ☐ Cuban ☐ Guatemalan ☐ Honduran ☐ Mexican, Mexican American or Chicano/a ☐ Other Hispanic, Latino/a or Spanish Origin ☐ Peruvian ☐ Puerto Rican ☐ Salvadoran ☐ Declined to Answer ☐ Unknown

Primary Care Provider (PCP) Name:

EMERGENCY CONTACT & ACCESS TO INFORMATION / ADVANCE DIRECTIVES:

Emergency Contact Name and Relationship:		
Emergency Contact Phone #:		Is the Emergency Contact the Patient's Legal Guardian? YES NO
The following people may have access to my medical information (please list name(s) and relationship(s) to patient):		
Do you have any of the following:	__ Medical Power of Attorney ___ Living Will ___ DNR ___ GA Advance Directives	

GUARANTOR INFORMATION:

Who is financially responsible for this account? SELF EMPLOYER SPOUSE FATHER MOTHER OTHER

Employer Name:

Employment Status:
☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Disabled ☐ Not Employed ☐ Active Military Duty ☐ Other / Unknown

Student Status:
☐ Full Time ☐ Part Time

Primary Insurance Company:		**Secondary Insurance Company:**	
Subscriber Name:		Subscriber Name:	
Subscriber Sex: M / F	Date of Birth:	Subscriber Sex: M / F	Date of Birth:
Subscriber Home Phone #:		Subscriber Home Phone #:	
Subscriber ID #:	Group #:	Subscriber ID #:	Group #:

Signature of Patient or Legal Guardian | Printed Name of Patient or Legal Guardian | Date | Time