

### NEW PATIENT DEMOGRAPHIC FORM

PATIENT DATA						
DATE	LAST NAME, FIRST NAME	MI	DOB	AGE	SS#	
<b>RACE</b> (for reporting purposes only) <input type="checkbox"/> Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Other: _____		<b>ETHNICITY</b> <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Decline to Answer  <b>SEX</b> <input type="checkbox"/> F <input type="checkbox"/> M <b>LANGUAGE</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		<b>CURRENT MAILING ADDRESS</b> (street address, city, state, zip)		
<b>PRIMARY PHONE</b> (circle type) HOME CELL BUSINESS		<b>ALTERNATE PHONE</b> (circle type) HOME CELL BUSINESS		<b>EMAIL</b>		
<b>EMPLOYER NAME &amp; ADDRESS</b> (street address, city, state, zip)			<b>BUSINESS PHONE</b>		<input type="checkbox"/> Please send me information via email to access my VHA health records online.	
			<b>EMPLOYMENT STATUS/OCCUPATION</b>			
<b>CLINICAL INFORMATION</b>						
<b>REFERRING PHYSICIAN</b>			<b>PRIMARY CARE PHYSICIAN</b> (if different)			
<b>PREFERRED PHARMACY</b> (name, address or cross streets, and phone number)			If you do not identify a PREFERRED PHARMACY, we will send your prescriptions to be filled at: CVS 180 N Dobson Road (NW corner of Dobson & Chandler Blvd) Chandler, AZ 85224 (480) 812-0149  *Please note you can update our records at any time regarding your choice of pharmacies.			
<b>IN CASE OF EMERGENCY</b>						
<b>NAME &amp; ADDRESS</b> of friend/relative for Emergency Contact			<b>RELATIONSHIP</b>			
			<b>PRIMARY PHONE</b> (circle type) HOME CELL BUSINESS		<b>ALTERNATE PHONE</b> (circle type) HOME CELL BUSINESS	
<b>RESPONSIBLE PARTY</b>						
<b>NAME</b> of RESPONSIBLE PARTY			<b>DOB</b>	<b>SS#</b>	<b>RELATIONSHIP</b>	
<b>CURRENT MAILING ADDRESS</b> (street address, city, state, zip)			<b>PRIMARY PHONE</b>		<b>CELL PHONE</b>	
			<b>EMAIL</b>		<b>ALT PHONE</b>	
<b>EMPLOYER &amp; ADDRESS</b> (street address, city, state, zip)			<b>BUSINESS PHONE</b>			
			<b>OCCUPATION</b>			
<b>INSURANCE INFORMATION</b>						
<b>PRIMARY INSURANCE COMPANY</b> (name, address & PHONE)			<b>POLICY HOLDER NAME</b>		<b>DOB</b>	
			<b>GROUP #:</b>			
			<b>CLAIM MEMBER ID:</b>			
<b>SECONDARY INSURANCE COMPANY</b> (name, address & PHONE)			<b>POLICY HOLDER NAME</b>		<b>DOB</b>	
			<b>GROUP #:</b>			
			<b>CLAIM MEMBER ID:</b>			