Post Falls Family Medicine, P.A.

Patient Demographic Information

Today's Date: __________________ How did you hear about us? ___________________________

PATIENT INFORMATION

Name: ____________________________________ Nickname: _______________ Previous/Maiden Name: ________________
Male: __Female: __ **Date of Birth**: ________Age: _____Social Security #: ______________ Email: ________________________
Single: _____ Married: _____ Divorced: _____ Widowed: _____

Physical Address: _______________________________________City: ___________________ State: _____ Zip: ____________
Mailing Address: ____ City: _____________________ State: _____ Zip: _________

Home: ______________________ Cell/Alternative: _______________________ Work Phone: __________________________
Which phone number is preferred? Home _____ Cell _____ Work ______ Language Preference: ______________

Race (government census):
White_____ American Indian or Alaskan Native ______ Asian _____ Black or African American _____ Native Hawaiian or Other Pacific Islander _______Decline to Specify_______
Ethnicity:
Hispanic or Latino _______ Not Hispanic or Latino _______ Declined to specify_______

Employer: ____ **Phone**: ____
Employer Address: ______________________________________ City: ______________________ State: ____ Zip: _________

FRIEND OR RELATIVE **NOT** LIVING WITH YOU THAT WE MAY CONTACT IF WE ARE UNABLE TO REACH YOU:

Name: ____ Relationship: ____________________ Phone: __________________
Address: _______________________________________City: ________________________ State: _____ Zip: _______________

PERSON RESPONSIBLE FOR ACCOUNT
Please note, just because a spouse/parent carries the insurance plan, does not mean they are responsible for the balance due after insurance has processed.
☐ Self

Name: ____ Phone/Cell: _______________________________________
Relationship: __________________________ Social Security #: _____________________ Date of Birth: _________________
Employer: ____ Employer Phone: __________________________________
Address: ____ City: _________________________ State: ______Zip: ___________

PATIENT'S SPOUSE INFORMATION
☐ N/A

Name: ____________________________________Date of Birth: ____________ Social Security #: ______________________
Employer: ____________________________________ Work Phone: ____________________ Cell/Alt: ___________________

Please list all other family members that are seen here: (i.e. mom, dad, siblings)
____
____
Who referred you? ___________________________