PIEDMONT INTERNAL MEDICINE

PATIENT INFORMATION

Patient Name: _____ **Today's Date:** _____

Social Security Number: (Last 4 Digits) _____ **Birth Date:** _____ **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Home Address: _____

Phone Numbers: Primary _____ **Work** _____**Email** _____

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Race/Ethnicity: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Hispanic/Latino ☐ Other _____

Emergency Contact Name: _____**Phone Number:** _____
Relationship to Patient: _____

Whom may we thank for referring you? _____

EMPLOYMENT INFORMATION

Employer: _____ **Position:** _____

Employer's Address: _____

PREFERRED PHARMACY

Pharmacy Name: _____ **Phone:** _____

Pharmacy Address: _____

INSURANCE INFORMATION

Responsible Party: If patient check here: ☐

Name:_____ **Date of Birth:**_____ **Relationship:**_____

Phone Number: _____**Address**:_____

Primary Insurance Co: _____ **Group Number:** _____

Subscriber's Name: _____ **ID Number:** _____

Relationship to Patient: _____ **Date of Birth** _____ **Ins. Phone Number** _____

Secondary Insurance Co: _____ **Group Number:** _____

Subscriber's Name: _____ **ID Number:** _____

Relationship to Patient: _____ **Date of Birth:** _____**Ins. Phone Number:** _____

(PLEASE BRING YOUR INSURANCE CARD AND PHOTO ID TO ALL APPOINTMENTS)