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)