BAPTIST HEALTH MEDICAL GROUP
Patient Demographic Information Form
Please Print Legibly

Date: __________

Full Name: ______________________ Date of Birth: ____________ SSN: ____________
Age: ______ Sex: ______ Marital Status: ________ Email Address: ________________

Address: ____
City: ______________________________ State: ______ Zip Code: __________
Home Ph: __________________ Cell Ph: __________________ Work Ph: ________________

Race: (circle one) White – Black/African American – Asian – Native American/Alaska – Native Hawaiian /Pacific Islander – Decline

Ethnicity: (circle one) Hispanic/Latino – Non Hispanic Latino – Decline Race: ______________________

Preferred Language: ______________ Written Language: ____________ Needs Interpreter? Yes / No

Emergency Contact: __________________ Relationship: ___________ Ph: _______________

Primary Physician: _________________ Ph: _____________ Referring Physician: ______________

Employer: ________________________________ Ph: ________________________

Employment Status(circle one): FT – PT – Not Employed – Military Duty – Self Employed – Disabled – Student FT – PT

Guarantor Information: (Information of person financially responsible for a minor under age 18)

Guarantor Name: __________________________ Relationship to Patient: ______________
SSN: ____________________ Date of Birth: ____________________ Sex: __________
Home Ph: __________________ Cell Ph: __________________ Work Ph: ________________
Guarantor Address: ____
City: ______________________________ State: ______ Zip Code: __________

Employment Status(circle one): FT – PT – Not Employed – Military Duty – Self Employed – Disabled – Student FT – PT

Guarantor Employer: ____________________________ Ph: ________________________

Insurance / Subscriber Information

Primary Insurance: ________________________ Policy ID#: ________________________
Group #: ________________________ Effective Date: ________________________
Subscriber Name: ________________________ Subscriber SSN: ________________________
Subscriber Date of Birth: ________________________ Relationship to Pt: ________________________
Subscriber Address: ____
City: ________________________ State: ____________ Zip Code: ________________

Secondary Insurance: ________________________ Policy ID#: ________________________
Group #: ________________________ Effective Date: ________________________
Subscriber Name: ________________________ Subscriber SSN: ________________________
Subscriber Date of Birth: ________________________ Relationship to Pt: ________________________
Subscriber Address: ____
City: ________________________ State: ____________ Zip Code: ________________