OSTEOPATHIC FAMILY WELLNESS CENTER
April R. Smith-Gonzalez, DO MPH
Board Certified in Family Medicine and Osteopathic Manipulative Treatment

PATIENT DEMOGRAPHIC FORM

(THIS FORM IS TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES)

Patient Name: _____ Date of Birth: _____
First M Last

Social Security #: _____-_____-_____Gender: ☐ M ☐ F Marital Status: ☐S ☐M ☐W ☐D

Race: _____ Ethnicity: ☐ Hispanic/Latino ☐N on-Hispanic/Latino

Mailing Address: _____City: _____State: _____ Zip: _____

Home Ph #: _____ Cell #: _____

E-mail: _____

Employer: _____ Work Phone: _____

Preferred Contact Method: ☐ Home ☐ Cell ☐ Work Message OK: ☐ Home ☐ Cell ☐ Work

Pharmacy: _____ Pharmacy Number: _____
Location Phone

Are we your Primary Care Provider? ☐ Yes ☐ No
If no, who is? _____ _____
Provider Number

EMERGENCY

Name & **Relationship** Phone May we disclose PHI:
☐ Medical ☐ Financial
_____ _____

INSURANCE INFORMATION:

Primary:
Insurance Co.: _____ Member ID #: _____

Group #: _____ Subscriber Information: _____
Name DOB Relationship

Secondary:
Insurance Co.: _____ Member ID #: _____

Group #: _____ Subscriber Information: _____
Name DOB Relationship

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