# Patient Demographics Form

**Full Legal Name:** ___________________________________________

**Date of Birth:** _________________ **Gender (M/F/Other (specify other)):** ________________

**Home Address:** ________________________________________________________________

**Race:** _______________ **Mobile #:** ___________________ **Home #:** ___________________

**Can your Mobile phone do texting (SMS) and/or video calls?:** _________________________

**Email Address:** ______________________________________

**How do you prefer to be contact? (list in order of preference):** ________________________

**May we leave you detailed messaged with protected health information? (Y/N):** __________

**Emergency Contact Information:**

**Name:** ___________________________ **Phone #:** _________________ **Relation:** __________

**Would you like to authorize anyone (family or friend) to receive your Protected Health Information (PHI)?**

**Name:** ___________________________ **Phone #:** _________________ **Relation:** __________

**Were you referred to us by another provider? If so, who?:** ___________________________

**Who is your Primary Care Physician and phone number?:** ___________________________

**Please describe your current and past professions:** __________________________________

**Employer Name and Address:** ____________________________________________________

**Do you have insurance?(Y/N):** _________________ **Insurance Name:** __________________

**Responsible Party (Self/Specify Other): ________________________________________**

**What is your preferred pharmacy? (name and address): ___________________________**

I hereby assign, transfer, and set over to Alamo Diabetes and Endocrinology all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

__________________________________

**Patient Name or Parent/Legal Guardian**

____________________________________ ___________________

**Patient Name or Parent/Legal Guardian Signature** **Date**