East Valley Cardiology

Specializing in Diseases of the Cardiovascular System

PATIENT DEMOGRAPHIC FORM

PATIENT DATA

DATE	Patient LAST NAME	FIRST NAME	MI	DOB	AGE	SS#

RACE
- ☐ Caucasian
- ☐ Black/African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other:_____

ETHNICITY
- ☐ Latino / Hispanic
- ☐ Other
- ☐ I prefer not to report this information

SEX
- ☐ Female
- ☐ Male

MARITAL STATUS
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

CURRENT MAILING ADDRESS (street address, city, state, zip)

ADDITIONAL MAILING ADDRESS

PRIMARY PHONE ☐ Home ☐ Cell ☐ Work

ALTERNATE PHONE ☐ Home ☐ Cell ☐ Work

EMAIL

EMPLOYER NAME & ADDRESS (street address, city, state, zip)

BUSINESS PHONE

FAX

OCCUPATION

CLINICAL INFORMATION

REASON FOR VISIT

REFERRING PHYSICIAN

PRIMARY CARE PHYSICIAN

PREFERRED PHARMACY (name, address and/or cross streets)

PHARMACY PHONE

IN CASE OF EMERGENCY

NAME & ADDRESS of nearest relative (NOT LIVING WITH PATIENT)

RELATIONSHIP

PRIMARY PHONE ☐ Home ☐ Cell ☐ Work

ALTERNATE PHONE ☐ Home ☐ Cell ☐ Work

RESPONSIBLE PARTY

NAME of RESPONSIBLE PARTY (if not same as above)

DOB

SS#

RELATIONSHIP

CURRENT MAILING ADDRESS (street address, city, state, zip)

PRIMARY PHONE ☐ Home ☐ Cell ☐ Work

ALTERNATE PHONE ☐ Home ☐ Cell ☐ Work

EMAIL

EMPLOYER & ADDRESS(street address, city, state, zip)

BUSINESS PHONE

FAX

OCCUPATION

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY (name, address & PHONE)

POLICY HOLDER NAME

GROUP #

CLAIM MEMBER ID

SECONDARY INSURANCE COMPANY (name, address & PHONE)

POLICY HOLDER NAME

GROUP #

CLAIM MEMBER ID