

Over 18 Patient Demographic

Patient (last,first,middle): _____ **Nickname:** _____

Date Of Birth: _____ **Gender** (please circle one): Male Female **Adopted** (please circle one): Yes No

Resides With (please circle one) : Mom Dad Both Other _____

Ethnicity (please circle one):

Unknown Hispanic or Latino Not Hispanic or Latino Other

Race (please circle one):

American Indian Or Alaskan Native Asian Black or African-American
White Declined to specify Hawaiian Native or Pacific Islander

Preferred Location (please circle one): Marietta Towne Lake Roswell

Preferred PCP: _____

Primary Home Address: _____ **Patient Phone Number:** _____

Street: _____

City, State, Zip: _____

Primary Email: _____

Emergency Contact (other than parent):

Name: _____ **Phone:** _____

Whom may we contact for the following:

Confirmation calls: _____ **Phone:** _____

Clinical Information: _____ **Phone:** _____

Billing Information: _____ **Phone:** _____

As a patient 18 years or older, I have been made aware of my right to privacy. My PHI/EHI (Personal/Electronic Health Information) may be released to:

Please circle one: No one except myself The following person(s) listed below

Name(last,first): _____

Name(last,first): _____

Patient Signature: _____ **Date:** _____