WAVERLY HEALTH CENTER

Adult Patient Demographics

Date: ______________________ Family Doctor: ______________________

Patient's Name: ____
First Middle Initial Last

Maiden/Previous Name: ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Life Partner Age: _____

Birth Date: ______________________ Social Security #: ______________________

Physical Address: ____
Street City State County Zip

Mailing Address: ☐ Same as above ____
Street City State County Zip

Home Phone: ______________________ Living Will: ☐ Yes ☐ No

Cell Phone: ______________________ Does the clinic have a copy? ☐ Yes ☐ No

Work Phone: ______________________ Are you a full-time student? ☐ Yes ☐ No

Email Address: ______________________

Other Demographic Information

Sex: ☐ Male ☐ Female **Preferred Language:** ______________________

Race: ☐ Asian ☐ Black ☐ Caucasian ☐ Hawaiian/Pacific Islander ☐ American Indian/Alaska Native
☐ Hispanic ☐ Decline to Answer ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline to Answer

Person to Contact in an Emergency

Name: ______________ Relationship: ______________ Phone: ______________

Name: ______________ Relationship: ______________ Phone: ______________

Insurance Information

Policy Holder: ______________________ Policy Holder: ______________________
Policy Holder Birth Date: ______________________ Policy Holder Birth Date: ______________________
Primary Insurance: ______________________ Secondary Insurance: ______________________
Member Number: ______________________ Member Number: ______________________
Group Number: ______________________ Group Number: ______________________
Claims Address: ______________________ Claims Address: ______________________
Phone Number: ______________________ Phone Number: ______________________

Guarantor/Person Responsible for Charges

Name: ______________________ Phone: ______________________

Signature: ______________________ Date: ______________________