AIKEN Physicians Alliance

Patient Demographics

Please fill out completely

Patient Information			
Last Name:	**First Name:**	**Middle Initial:**	
Gender: M / F	**Date of Birth:**	**Social Security #:**	
Mailing Address:	**City:**	**State:**	**Zip Code:**
Physical Address:	**City:**	**State:**	**Zip Code:**
Home Phone: ( )	**Cell Phone:** ( )	**Work Phone:** ( )	
Would you like to receive Appointment Reminders? Select one:__ Text __Email __Home Phone __Cell Phone			
Race: __ American Indian __Asian __African American __Pacific Islander __Caucasian __ Other			
Ethnicity: __ Hispanic __Non-Hispanic			
Who is your Primary Care Physician?			
Email Address: _____ Patient Portal Enrollment: __Yes __No			
How were you referred to our office? _____			
Financial Responsibility			
Are you Employed? __Yes __No If yes, please list Employer and Occupation.			
Do you have Health Insurance? __Yes __ No, I am Self-Pay **If yes, please be sure to present your insurance card(s) to our receptionist.**			
Do you plan to file Worker's Compensation? __Yes __No If yes, who should we call to verify? **Company Name:** **Person to Verify:** **Phone Number:** ( )			

_____ _____

Signature of Patient, Parent, or Guardian Date

_____

Printed Name of Patient, Parent or Guardian