VITALITY NW
NATURAL MEDICINE CLINIC

Vitality Natural Medicine, PC

Patient Demographic Form

Date: _____/_____/_____

Referral Source: _____

PATIENT INFORMATION

Name (First, MI, Last): _____

Gender Identity: _____

Preferred pronouns: _____

Sex assignment at birth: _____

Address: _____

Social Security #: _____

City, State, Zip:

Date of Birth: ____/____/_____

Marital Status: [ ] Married [ ] Domestic Partnership [ ] Single [ ] Divorced [ ] Widowed

Primary Phone: _____

Work Phone: _____

EMERGENCY CONTACTS

Name / Relationship / Phone

_____

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_____

PATIENT EMPLOYMENT INFORMATION

[ ] Employed [ ] Retired [ ] Unemployed [ ] Other

Employer's Name: _____

Employer's Phone: _____

Occupation: _____

INSURANCE INFORMATION

[ ] PRIVATE PAY

Ins. Company: _____

ID#: _____

Group/Policy #: _____

Group/Policy Name: _____

Subscriber's Name: _____

Subscriber's SSN: _____

Relationship to Patient: _____

Subscriber's Date of Birth: _____

Subscriber's Employer: _____

RESPONSIBLE PARTY (if patient is under 18 years of age)

Name: _____

Employer: _____

Address: _____

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Home Phone: _____

Patient Signature or Authorized Signature

_____