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/P.O. Box 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

Are you employed? ☐ Yes ☐ No Employer: _____

Email Address: _____

Other Demographic Information

Birth Sex: ☐ Male ☐ Female **Preferred Language**: _____

Sexual Orientation: ☐ Lesbian/Gay/Homosexual ☐ Straight/Heterosexual ☐ Bisexual ☐ Unknown ☐ Decline to Answer

Gender Identity: ☐ Male ☐ Female ☐ Female-to-Male/Transgender Male
☐ Male-to-Female/Transgender Female ☐ Genderqueer ☐ Decline to Specify

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

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

Preferred Pharmacy: _____

Insurance

Card Holder: _____ Card Holder Date of Birth: _____

Insurance Company: _____ Member Number: _____

Person to Contact in an Emergency

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I certify that the above information is accurate.

Signature: _____ Date: _____