

(please print)

Full legal name: \_\_\_\_\_ Preferred name: \_\_\_\_\_  
Last First Middle

Date of birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
Month/Day/Complete year

Sex at birth:  Male  Female  Intersex  
Gender identity:  Man  Woman  Transwoman  
 Transman  Nonbinary  Another unlisted  
What are your pronouns?  He/Him  She/Her  They/Them  Another

Primary care physician: \_\_\_\_\_

Preferred pharmacy name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Marital status:  Single  Married  Divorced  Widowed  Life partner  Legally separated  
Ethnicity:  Hispanic/Latino  Non-Hispanic/Non-Latino  Refused/Decline  
Race:  Caucasian (white)  American Indian  African American (Black)  Hispanic  
 Biracial  Asian  Other  Unknown

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Mail to address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

County: \_\_\_\_\_ Home phone: ( ) \_\_\_\_\_ Cellphone: ( ) \_\_\_\_\_

Preferred language: \_\_\_\_\_ Email: \_\_\_\_\_

Veteran: \_\_\_Yes \_\_\_No \_\_\_Unknown Religion: \_\_\_\_\_

**Guarantor information** (If guarantor is self, skip to emergency contact)

**Parent/guardian** presenting minor child for treatment will be listed as the guarantor. If 18 or older, patient will be listed as guarantor and does not have to complete this section. The guarantor will be responsible for any balance due.

Name: \_\_\_\_\_ Patient relation to guarantor: \_\_\_\_\_  
Last First Middle Home phone: ( ) \_\_\_\_\_

Date of birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Cellphone: ( ) \_\_\_\_\_

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Country: \_\_\_\_\_

Mail to address (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Country: \_\_\_\_\_

**Emergency contact** (Pediatric patients, please list someone other than parent(s)/guardian)

Primary contact name: \_\_\_\_\_ Home phone: ( ) \_\_\_\_\_

Patient relation to emergency contact: \_\_\_\_\_ Cellphone: ( ) \_\_\_\_\_

Secondary contact name: \_\_\_\_\_ Home phone: ( ) \_\_\_\_\_

Patient relation to emergency contact: \_\_\_\_\_ Cellphone: ( ) \_\_\_\_\_

**Employment**

Patient employer: \_\_\_\_\_ Work phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Employment status:  Full time  Part time  Self-employed  Active military  Student full time  
 Student part time  Retired date \_\_\_\_\_  Disabled  Not employed  Unknown

**(Pediatric patients only) Parent/Guardian & immediate family information**

**Mother** (If the address, phone numbers and employer information are the same as guarantor, please indicate same.)

Full name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Last First Middle Date of birth: \_\_\_\_\_

SS#: \_\_\_\_\_ Month/Day/Complete year

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

(if different from patient)

Home phone: \_\_\_\_\_ Cellphone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

**Father** (If the address, phone numbers and employer information are the same as guarantor, please indicate same.)

Full name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Last First Middle Date of birth: \_\_\_\_\_

SS#: \_\_\_\_\_ Month/Day/Complete year

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

(if different from patient)

Home phone: \_\_\_\_\_ Cellphone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

Patient name \_\_\_\_\_

DOB \_\_\_\_\_

**(Pediatric patients only) Brothers, sisters & other family members**

Full name	M or F	Date of birth	Relationship	Lives with child	
				Yes	No

Check here if no insurance. And skip to authorization (below).

**Accident information**

Is visit the result of an accident? (Examples: auto accident, workers compensation, etc.)  Yes  No

Type of accident: \_\_\_\_\_ Date of accident: \_\_\_\_\_ County of accident: \_\_\_\_\_

**Primary insurance information**

**SUBSCRIBER: This is the person who carries the insurance. If subscriber is the patient, skip to insurance co. name field.**

Subscriber's name on card: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Month/Day/Complete year

Patient relationship to subscriber: \_\_\_\_\_ Sex:  Male  Female

**If address and phone number is same as patient, please indicate same.**

Address: \_\_\_\_\_ SS#: \_\_\_\_\_

City, state, ZIP: \_\_\_\_\_ Home phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_ Ext. \_\_\_\_\_

Insurance co. name: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy/Cert #: \_\_\_\_\_ Group no.: \_\_\_\_\_ Effective date: \_\_\_\_\_

Subscriber Status:  Full time  Part time  Self-employed  Active military  Student full time  
 Student part time  Retired date \_\_\_\_\_  Disabled  Not employed

**Secondary insurance information**

**SUBSCRIBER: This is the person who carries the insurance. If subscriber is the patient, skip to insurance co. name field.**

Subscriber's name on card: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Month/Day/Complete Year

Patient relationship to subscriber: \_\_\_\_\_ Sex:  Male  Female

**If address and phone number is same as patient, please indicate same.**

Address: \_\_\_\_\_ SS#: \_\_\_\_\_

City, state, ZIP: \_\_\_\_\_ Home phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_ Ext. \_\_\_\_\_

Insurance co. name: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy/Cert #: \_\_\_\_\_ Group no.: \_\_\_\_\_ Effective date: \_\_\_\_\_

Subscriber status:  Full time  Part time  Self-employed  Active military  Student full time  
 Student part time  Retired date \_\_\_\_\_  Disabled  Not employed

**Authorization**

*I authorize medical evaluation and treatment, and release of information for insurance/medical purposes concerning my illness and treatment. I hereby authorize payment from my insurance company to Prisma Health for services rendered. I will be responsible for any amount not covered by my insurance.*

Signature of patient/guardian/guarantor: \_\_\_\_\_ Date: \_\_\_\_\_