ACCT# _____

For office use only.

Ironwood Physicians, PC

PATIENT DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

NAME : _____ DOB: _____ MARITAL STATUS: _____

ADDRESS: _____ CITY/ZIP: _____

SOCIAL SECURITY: _____ IS ARIZONA YOUR PERMANENT RESIDENCE? Y/N

SECONDARY ADDRESS (IF APPLICABLE)

ADDRESS: _____ CITY/ZIP: _____

CONTACT INFORMATION - Check preferred method of contact

HOME: _____ ☐

CELL: _____ ☐

OTHER: _____ ☐

EMAIL: _____ ☐

OK TO LEAVE A DETAILED VOICEMAIL? Y/N

ARE YOU CURRENTLY WORKING? Y/N

DISABLED? Y/N RETIRED? Y/N

IS YOUR SPOUSE CURRENTLY WORKING? Y/N

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

REFERRING PHYSICIAN: _____ PHONE: _____

RESPONSIBLE PARTY - Other than the patient

NAME: _____ RELATIONSHIP: _____ PHONE: _____

ADDRESS: _____ CITY/ZIP: _____

EMPLOYMENT INFORMATION Person responsible for payment

EMPLOYER NAME: _____ EMPLOYER PHONE: _____

EMPLOYER ADDRESS: _____ CITY/ZIP: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ PHONE: _____

INSURED NAME: _____ DOB: _____

POLICY #: _____ GROUP #: _____

SECONDARY INSURANCE: _____ PHONE: _____

INSURED NAME: _____ DOB: _____

POLICY #: _____ GROUP #: _____

HOW DID YOU HEAR ABOUT US? Please check the following

☐ BILLBOARD ☐ COMMERCIAL ☐ WEBSITE ☐ OTHER: _____

☐ SOCIAL MEDIA: ☐ FACEBOOK ☐ TWITTER ☐ LINKEDIN ☐ INSTAGRAM ☐ YOUTUBE ☐ PINTEREST

PATIENT SIGNATURE/RESPONSIBLE PARTY: _____ DATE: _____