

SCANNED:  
INITIAL:  
DATE:



# New Patient Demographics

Patient Name \_\_\_\_\_

Guardian Name (If Applicable) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

- Preferred Number: Home or Cell

Email: \_\_\_\_\_

- Would you like to sign up for our online patient portal to access your records at your convenience? Yes or No

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Last 4 of SSN: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_

Primary Care Doctor's Address \_\_\_\_\_

Date of Last Primary Care Visit \_\_\_\_\_

Doctor who Manages your Diabetes \_\_\_\_\_

Date of Last Diabetes Management Visit \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone# \_\_\_\_\_

Work Status \_\_\_\_\_ Date of last eye exam \_\_\_\_\_

Do you have an Advance Directive? If so, who? \_\_\_\_\_

Do you have a Power of Attorney? If so, who? \_\_\_\_\_