UL Physicians

PATIENT INFORMATION FORM

Patient Information Name _____ Also Known As _____

SSN _____ Date of Birth _____ Sex ☐Male ☐Female

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated Preferred Language_____

Special Needs ☐Adult Sitter/Guardian ☐Ambulates with Assistive Dev ☐Hearing Impaired ☐Sight Impaired ☐Multiple Birth ☐Speech Impaired ☐Wheelchair ☐Interpreter ☐Transportation Needs

Patient Race: Race – a human population considered distinct based on physical characteristics.	Ethnicity: Ethnicity a term which represents social groups with a shared history, sense of identity, geography and cultural roots which may occur despite racial difference.
☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Declined	☐Hispanic or Latino ☐ Not Hispanic or Latino Religion _____

Home Address_____

City, St_____County_____ Zip Code _____

Home Phone _____ Cell Phone_____ Work/Other Phone _____

Email _____

By providing my email address I acknowledge that I may receive health care surveys and other health care related communications. I understand this is not to be used for provider communication and that email is not secure and can be intercepted and used by unauthorized persons.

Employment Status _____Employer Name _____

Employer Phone _____ Employer Address_____

Employer City, St _____ Zip Code_____

Primary Physician _____ Primary Physician Phone _____

Referring Physician _____ Referring Physician Phone _____

Preferred Pharmacy_____ Pharmacy Phone _____

Pharmacy Address, City, St, Zip _____

Parent/Guardian(s) or Spouse Information Name_____

Relationship to Patient _____ SSN _____ Date of Birth _____

Address (If Different) _____ Zip Code_____

Employer _____ Employer Phone _____

Employer Address _____ Zip Code_____

Home Phone _____ Cell Phone _____ Email _____

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Patient Name: _____ Patient DOB_____

Emergency Contact (someone other than a parent and who does not live with the patient or a parent)

Name _____ Relationship _____ Phone _____

Parent/Guardian #2 Name_____

Relationship to Patient _____ SSN _____ Date of Birth _____

Address (If Different) _____ Zip Code_____

Employer _____ Employer Phone Number _____

Employer Address _____ Zip Code_____

Home Phone _____ Cell Phone _____ Email _____

Medical Insurance Info.	Primary Insurance	Secondary Insurance
Subscriber ID		
Group or Plan Number		
Plan/Program Code		
Insurance Co. Name		
Insurance Co. Phone Number		
Patient Relation to Subscriber		
Subscriber Name		
Subscriber Street Address		
Subscriber City and State		
Subscriber Zip Code		
Subscriber Date of Birth		
Subscriber Sex		
Subscriber Social Security #		
Subscriber Employer		
Co-pay Amount		

Injury Related Information ☐Work Related ☐Auto ☐Motorcycle ☐Other Date & Time of Injury _____

State Where Injury Occurred _____Contact Name _____ Phone _____

Claim # _____ Insurance Co. _____

Insurance Co. Address, City, St, Zip _____

_____ _____

Patient/Parent/Legal Guardian/Legal Authorized Representative Signature Date

If Parent/Legal Guardian/Legal Authorized Representative, Print Name _____