# Mobile Health Team Adult Demographics Form

Patient's name full name: _____ *Male* or *Female* D.O.B:_____

Today's date _____ Referred by: _____

Address: _____

Street City State Zip

Home Phone: _____ Cell: _____ Work Phone: _____

Employer: _____ Occupation: _____

Email Address: _____

**PRIMARY INSURANCE & RESPONSIBLE PARTY INFORMATION**

Insurance company: _____

Policy/ID/Subscriber Number: _____ Group Number_____

Primary Insured Name_____ D.O.B:_____SSN:_____

Employer: _____

Address (if different from above):_____

Street City State Zip

Phone (if different from above): _____

**SECONDARY INSURANCE INFORMATION** ☐ **NONE**

Insurance company: _____Primary Insured's Name _____

Policy/ID/Subscriber Number: _____ Group Number_____

**EMERGENCY CONTACT INFORMATION**

Name:_____ Relation: _____ Phone: _____

**CONTACT PREFERENCES:**

Preferred Phone for contact: ☐ Home ☐ Cell ☐ Work

May we send you appointment reminders by: ☐ Email? ☐ Mobile Text?

If we are unable to reach you by phone, may we leave a message? ☐ No

☐ Yes, but only messages with appointment times or callback information

☐ Yes, my preferred phone is secure. You may leave detailed health Information.

**THERE ARE MANY WAYS WE CAN PROVIDE YOU WITH SUPPORT! WOULD YOU LIKE FURTHER INFORMATION FROM US ON:**

☐ Patient Portal for viewing your medical records and securely emailing/messaging us

☐ Tele-health (Video Medical Appointments) ☐ In-Person Classes

☐ Online Classes ☐ Health Apps for Devices

☐ Email Newsletter (If a different email is preferred than above, list here): _____