CENTRAL OHIO PRIMARY CARE

PATIENT DEMOGRAPHIC INFORMATION - ADULT

Please Complete This Entire Form. Thank You!

Today's Date: _____/_____/____ **Referred By *(If Applicable)*: _____**

PATIENT INFORMATION **OFFICE USE (P#):**

LAST NAME:	**LEGAL FIRST NAME:**	**MIDDLE INITIAL:**	**DATE OF BIRTH *(mm/dd/yyyy)*:**
PREFERRED NAME:	**HOME PHONE:** ( )	**CELL PHONE:** ( )	**PRIOR NAME(S):**

GENDER IDENTITY: □ Male □ Female □ Female-to-Male (FTM) /Transgender Male/Trans Man
□ Male-to-Female (MTF) /Transgender Female/Trans Woman □ Genderqueer or Non-Binary
□ Choose not to disclose □ Something else, please describe:

GENDER PRONOUNS: □ she/her/hers □ he/him/his □ they/them/their □ Other: _____

SEX ASSIGNED AT BIRTH: □ Male □ Female □ Unknown

MARITAL STATUS: □ Single □ Married □Divorced □Widowed □ Separated

SEXUAL ORIENTATION:
□ Straight or Heterosexual □ Lesbian, Gay □ Bi-sexual □ Do not know □ Choose not to Disclose
□ Something else, please describe:

MAILING ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHYSICAL ADDRESS *(If different from mailing address):*	**CITY:**	**STATE:**	**ZIP:**

Preferred Pharmacy: **Pharmacy Telephone: ( )**

E-MAIL ADDRESS: □ None □ Prefer Not to Disclose	**USE E-MAIL ADDRESS FOR PATIENT PORTAL:** □ Yes □ No □ Not Applicable	**SOCIAL SECURITY #:**

RACE: □ American Indian/Alaskan Native □ Asian □ Black/African American
□ Native Hawaiian/Other Pacific Islander □ White □ Refuse to Report □ Other

PREFERRED LANGUAGE: □ English □ Spanish
□ Other (*please specify*):
Translator Needed: □ Yes □ No

ETHNICITY: □ Hispanic/Latino
□ Non-Hispanic/Latino
□ Refuse to Report

CURRENT LEVEL OF CARE: □ Hospice
□ Permanent Nursing Facility (Long Term Care, Memory Care Unit) Facility Name:
□ Not Applicable

EMERGENCY CONTACT

LAST NAME:	**FIRST NAME:**	**RELATIONSHIP *(Please specify)*:**
HOME PHONE: ( )	**CELL PHONE:** ( )	**MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL:** □ Yes □ No

PLEASE CONTINUE ON THE BACK SIDE OF THIS FORM

ADDITIONAL CONTACT (OPTIONAL)

LAST NAME:	FIRST NAME:	RELATIONSHIP *(Please specify)*:
HOME PHONE: ( )	CELL PHONE: ( )	MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: □ Yes □ No

EMPLOYER INFORMATION

EMPLOYER NAME:	EMPLOYER PHONE NUMBER: ( )
EMPLOYMENT STATUS: □ Employed □ Full Time □ Part Time □ Retired □ Self Employed □ Unemployed □ Active Military □ Student	

INSURANCE INFORMATION

(Please present all current insurance cards to the Front Desk)

I HAVE INSURANCE: □ Yes □ No *(Self Pay)*			
PRIMARY INSURANCE:		SECONDARY INSURANCE:	
SUBSCRIBER:	RELATION:	SUBSCRIBER:	RELATION:
SEX/GENDER with Insurance Company COPC recognizes your gender identity. For insurance/billing purposes, what sex/gender marker is on file with your insurance company? □ Male □ Female		SEX/GENDER with Insurance Company COPC recognizes your gender identity. For insurance/billing purposes, what sex/gender marker is on file with your insurance company? □ Male □ Female	
DATE OF BIRTH *(mm/dd/yyyy)*:	SOCIAL SECURITY #:	DATE OF BIRTH *(mm/dd/yyyy)*:	SOCIAL SECURITY #:

CONFIDENTIAL COMMUNICATION

(I hereby request to receive confidential communications from COPC in the following manner)

TELECOMMUNICATIONS –Please leave messages regarding my protected health information as follows (*Check Preferred*): □ Home Phone of Record □ Brief □ Extended □ Cell Phone of Record □ Brief □ Extended □ Work Phone of Record □ Brief □ Extended Example of Extended: Lab Results Example of Brief: Time/Day of Appointment	POSTAL COMMUNICATIONS –Please mail my protected health information to me at (*Select One*): □ Mailing Address of Record □ Street Address of Record □ Other: _____ Street Address City State Zip

ADVANCE DIRECTIVES

DO YOU HAVE A LIVING WILL? □ No □ Yes
(If yes, please provide a copy to the Front Desk)
DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE? □ No □ Yes
(If yes, please provide a copy to the Front Desk)
DO YOU HAVE A DO NOT RESCUSITATE? □ No □ Yes
(If yes, please provide a copy to the Front Desk)

HOW DID YOU HEAR ABOUT US?

□ Community Event □ COPC Website □ Facebook □ Health Plan Website □ Internet Search □ Online Reviews
□ Outdoor/ Billboard Advertisement □ Print Advertisement □ Radio Advertisement □ Television Advertisement
□ Referred by COPC Physician □ Referred from Friend/Family □ Other_____

FOR COPC SPECIALTY PATIENTS ONLY: PRIMARY CARE PROVIDER

Primary Care Provider:	PHONE NUMBER: ( )

_____ _____ _____
Patient Printed Name | Patient Signature | Date Signed

_____ _____ _____
Legal Guardian Printed Name (*if applicable*)* | Legal Guardian Signature (*if applicable*)* | Date Signed