ALEXANDRIA
FAMILY PRACTICE

Patient Information:

Name (last, first, middle initial): _____ Email Address: _____

Address: _____ Apt # _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female Social Security Number: _____ Preferred Language: _____

Phone Number (home): _____ Phone Number (alternate): _____ ☐ cell ☐ work

Specify number for reminder messages: ☐ home ☐ alternate I permit reminder calls to be left on my voicemail: ☐ yes ☐ no

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired Employer: _____
☐ Student ☐ Other _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____

Phone Number (home): _____ Phone Number (alternate): _____ ☐ cell ☐ work

Demographics: Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native
☐ More than one race ☐ Hispanic ☐ Declined ☐ Other _____

Ethnicity: ☐ American ☐ Asian Indian ☐ Caribbean Islander ☐ Chinese ☐ Eastern European ☐ Filipino
☐ Japanese ☐ Korean ☐ Middle Eastern ☐ North African ☐ Pakistani ☐ Vietnamese
☐ West African ☐ Declined ☐ Other _____

Insurance Information – We will request to scan your ID and insurance card.

Primary Insurance: _____ Patient is Subscriber/Policy Holder: ☐ Yes ☐ No

Member ID # _____ Provider/Insurance Services Phone Number _____

Secondary Insurance: _____ Patient is Subscriber/Policy Holder: ☐ Yes ☐ No

Member ID # _____ Provider/Insurance Services Phone Number _____

Insured Information (if other than patient):

Subscriber/Policy Holder: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____ Date of Birth: _____ Subscriber Employer: _____

Please indicate your referring provider in addition to other providers who will need your treatment information.

Primary Care Provider Name: _____

Address: _____ Phone Number: _____ Fax Number: _____

Specialty Care Provider Name: _____ Specialty: _____

Address: _____ Phone Number: _____ Fax Number: _____

Specialty Care Provider Name: _____ Specialty: _____

Address: _____ Phone Number: _____ Fax Number: _____

Patient/Parent/Guardian (signature): _____ Date: _____ Time: _____

Patient/Parent/Guardian (print name): _____ Relationship: _____

Interpreter Information

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed