

## IU Health Physicians

## **Ambulatory Registration**

## PATIENT DEMOGRAPHIC INFORMATION

Legal Name							Date of Birth	
_							State	
							SSN	•
,					•			
Gender: M	_		_		_			
Race:		or Alaska N Multiracia		Asian Jnknown		rican American	Native Hawaiian or	other Pacific Islander
Ethnicity:	Hispanic or Lati	no [	☐ Not Hispar	nic or Latino	☐ Dec	lined	Unknown	
Phone		_ Alternate	Phone		Emai	I Address		
Preferred Meth	nod of Communicat	ion: 🔲 l	Email 🔲 I	Mail 🗌 Ho	me Phone	Cell Phone	☐ Work Phone	Declined
Primary Care D	Ooctor				Referring I	Doctor		
Employment St	tatus (Circle One)	Full-time	Part-time	Disabled	Retired	Not Employed	Self Employed	On Active Duty
Employer Name	e						Employer Phone	
Retirement Da	te (if applicable)							
Accident: Da	ate		Time	Loca	ation			
PATIENT GUAF	RANTOR INFOR	MATION (	Complete if	other than p	atient)			
Patient Relatio	nship to Guaranto	r				Date of Birth		Gender: M F
Last Name				First Name .			SSN	
Address					City		State	Zip
Employment Si	tatus (Circle One)	Full-time	Part-time	Disabled	Retired	Not Employe	ed Self Employed	On Active Duty
Employer Name	e						Employer Phone	
Phone:		_ Alternate	e Phone		Ema	ail		
NEXT OF KIN (	Emergency Conta	act Person	Information	)				
Patient Relatio	nship to NOK						Date of Birth	
Last Name						First Name		MI
Phone:		_ Alternate	e Phone		Ema	ail		
Employer Nam	e						Employer Phone	
Alternate Cont	tact Information	Patient Rela	tionship to C	ontact Person			Date	of Birth
Last Name						First Name		MI
		Alternate	Phone					
INSURANCE IN			3 1 110110					
							nce	
			-					
							State	
Employer Nam							Employer Phone	
	Secondary Inform				Data of Dirth	NI-	me of Insurance	
							me of insurance Member ID:	
eg Non-Conf				="				
	Address Employer Name				•		•	
	Employer Name.						Employer Friorite	