ANMED HEALTH
PATIENT INFORMATION

IMPORTANT NOTICE

Due to HIPAA requirements, this form must be filled out completely.
Please ask for help if you have questions about any field.
We will be unable to file insurance for incomplete forms. Thank You.

PATIENT INFORMATION

Full Name:		Social Security #:	
Date of Birth:		Name you wish to be called:	

Legal Sex: (as on your driver's license)

Gender Identity:
- ☐ Female
- ☐ Male
- ☐ Choose not to disclose
- ☐ Transgender Female (male-to-female)
- ☐ Transgender Male (female-to-male)
- ☐ Other

Sex at Birth:
- ☐ Female
- ☐ Male
- ☐ Choose not to disclose
- ☐ Unknown
- ☐ Uncertain
- ☐ Not recorded on birth certificate

Sexual Orientation:
- ☐ Straight
- ☐ Lesbian or Gay
- ☐ Choose not to disclose
- ☐ Bisexual
- ☐ Don't Know
- ☐ Something else

Mailing Address:			
City, State, Zip:		County:	
Home Phone #:	Work Phone #:	Mobile #:	
Email Address:	I DON'T HAVE EMAIL NO THANKS		

Marital Status:
- ☐ Divorced
- ☐ Legally Separated
- ☐ Married
- ☐ Significant Other
- ☐ Single
- ☐ Widowed
- ☐ Other
- ☐ Unknown

Do you need an Interpreter? YES NO

Language Preference:

Written Language Preference:

Religion:

Race:
- ☐ American Indian / Alaska Native
- ☐ Asian Indian
- ☐ Asian
- ☐ Native Hawaiian / Other, Pacific Islander
- ☐ Black / African American
- ☐ White
- ☐ Unknown
- ☐ Declined

Ethnicity:
- ☐ Not Hispanic, Latino/a or Spanish origin
- ☐ Colombian
- ☐ Cuban
- ☐ Guatemalan
- ☐ Honduran
- ☐ Mexican, Mexican American or Chicano/a
- ☐ Other Hispanic, Latino/a or Spanish Origin
- ☐ Peruvian
- ☐ Puerto Rican
- ☐ Salvadoran
- ☐ Declined to Answer
- ☐ Unknown

Primary Care Provider (PCP) Name:	
Emergency Contact Name and Relationship:	
Emergency Contact Phone #:	Is the Emergency Contact the Patient's Legal Guardian? YES NO
Employer Name:	

Employment Status:
- ☐ Full Time
- ☐ Part Time
- ☐ Self Employed
- ☐ Retired
- ☐ Disabled
- ☐ Not Employed
- ☐ Active Military Duty
- ☐ Other / Unknown

Student Status:
- ☐ Full Time
- ☐ Part Time

GUARANTOR INFORMATION

Who is financially responsible for this account? SELF EMPLOYER SPOUSE FATHER MOTHER OTHER

Primary Insurance Company:	**Secondary Insurance Company:**
Subscriber Name:	Subscriber Name:
Subscriber Social Security Number:	Subscriber Social Security Number:
Subscriber Sex:	Subscriber Sex:
Subscriber Date of Birth:	Subscriber Date of Birth:
Subscriber Home Phone #:	Subscriber Home Phone #:
Subscriber ID #:	Subscriber ID #:
Subscriber Group #:	Subscriber Group #:

What is your preference of contact for appointment reminders? TEXT EMAIL PHONE

I authorize the following people access to my protected health or medical information (list name(s) and relationship(s) to patient):

Do you have Advanced Directives? YES NO If yes choose type: __ Health Care Power of Attorney/Living Will __ DNR

Preferred Pharmacy Name and Location:

Signature of Patient or Legal Guardian | Printed Name of Patient or Legal Guardian | Date | Time