

# UPMC Hamot Physician Network

## Demographic Form

Dear Patient,

In order for us to serve you better and ensure completeness of your information, please take a moment to provide us with the below information.

Legal Last Name: \_\_\_\_\_ Legal First Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Legal Sex: \_\_\_\_\_ Gender Identity: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: Hispanic/Latino  Non-Hispanic/Latino Not specified Decline

Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

If Patient is a minor, please list parent or guardian name: \_\_\_\_\_

### Emergency Contact:

Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Insurance Information

Primary Insurance Company Name: \_\_\_\_\_ PCP copay \$ \_\_\_\_\_ Spec copay \$ \_\_\_\_\_

Identification or Policy number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Social Security Number of policy holder: \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Secondary Insurance Company Name: \_\_\_\_\_ PCP copay \$ \_\_\_\_\_ Spec copay \$ \_\_\_\_\_

Identification or Policy number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Social Security Number of policy holder: \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_