DEMOGRAPHICS

Patient Demographics & Contact Information

Please complete all fields. This information helps us reach you, bill correctly, and personalize your care.

Patient Identity

LEGAL LAST NAME ____________ FIRST NAME ____________ MIDDLE INITIAL ____________

PREFERRED NAME ____________ DATE OF BIRTH ____________ SEX ASSIGNED AT BIRTH ____________ GENDER IDENTITY ____________

PRONOUNS ____________ SSN (LAST 4 ONLY) ____________ DRIVER'S LICENSE # ____________ STATE ____________

MARITAL STATUS

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Partnered
- ☐ Prefer not to say

Contact Information

HOME ADDRESS ____________ APT/UNIT # ____________

CITY ____________ STATE ____________ ZIP ____________ COUNTY ____________

MOBILE PHONE ____________ HOME PHONE ____________ WORK PHONE ____________ BEST TIME TO CALL ____________

EMAIL ADDRESS ____________ PREFERRED PHARMACY (NAME & LOCATION) ____________

Communication Preferences

- ☐ OK to leave detailed voicemail
- ☐ OK to leave brief voicemail (no PHI)
- ☐ OK to send text messages (reminders, brief notices)
- ☐ OK to send general email (no detailed PHI)
- ☐ Prefer patient portal for clinical messages
- ☐ Prefer mail to home address

Employment

EMPLOYER NAME ____________ OCCUPATION / JOB TITLE ____________

STATUS

- ☐ Full-time
- ☐ Part-time
- ☐ Retired
- ☐ Student

Demographics (Optional — for quality reporting)

RACE

- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian / Pacific Islander
- ☐ White
- ☐ Other / Multiple
- ☐ Prefer not to say

ETHNICITY

- ☐ Hispanic / Latino
- ☐ Not Hispanic / Latino
- ☐ Prefer not to say

PREFERRED LANGUAGE ____________

Emergency Contact

FULL NAME | RELATIONSHIP | PHONE

ADDRESS | EMAIL (OPTIONAL)

MAY WE SHARE MEDICAL INFORMATION WITH THIS PERSON?

- ☐ Yes — full information
- ☐ Yes — emergency only
- ☐ No

Secondary Contact (Optional)

FULL NAME | RELATIONSHIP | PHONE

MAY WE SHARE MEDICAL INFORMATION WITH THIS PERSON?

- ☐ Yes — full information
- ☐ Yes — emergency only
- ☐ No

Primary Care Provider (if not Rocket City Clinics)

PCP NAME & CREDENTIALS | PRACTICE NAME

ADDRESS | PHONE | FAX

MAY WE SHARE VISIT NOTES WITH YOUR PCP?

- ☐ Yes
- ☐ No
- ☐ Ask me each visit

Referral Source

HOW DID YOU HEAR ABOUT ROCKET CITY CLINICS?

- ☐ Friend / family
- ☐ Google search
- ☐ Social media
- ☐ Insurance directory
- ☐ Referred by another provider
- ☐ Drove by
- ☐ Online review
- ☐ Employer / wellness program
- ☐ Other

SPECIFY (PROVIDER NAME, SOURCE NAME, OR "OTHER")

Patient Attestation

I certify that the information provided on this form is true and complete to the best of my knowledge. I understand that providing false information may affect my care, billing, or eligibility for benefits. I will notify Rocket City Clinics of any changes to my contact information, insurance, or emergency contacts.

PATIENT SIGNATURE (OR AUTHORIZED REPRESENTATIVE) | DATE