



PATIENT INFORMATION FORM -- CONFIDENTIAL

CARILIONCLINIC

PATIENT INFORMATION

Full Legal Name (Last, First, MI) _____ ☐ Jr. ☐ Sr. ☐ II ☐ III ☐ Other _____

Preferred Name _____ SSN _____ Date of Birth _____

Legal Sex ☐ Male ☐ Female ☐ Nonbinary

Gender Identity ☐ Male ☐ Female ☐ Transgender Male (Female-to-Male) ☐ Transgender Female (Male-to-Female)
☐ Other _____ ☐ Choose Not to Disclose

Sex Assigned at Birth ☐ Male ☐ Female ☐ Unknown ☐ Not Recorded on Birth Certificate ☐ Choose Not to Disclose

Patient Pronouns ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other _____

Physical Address (Required) _____ City/State/Zip _____

Mailing Address (If Different) _____ City/State/Zip _____

Preferred Phone (____) _____ ☐ Home ☐ Cell ☐ Work ☐ Other _____

Secondary Phone (____) _____ ☐ Home ☐ Cell ☐ Work ☐ Other _____

Primary Care Provider _____ ☐ M.D. ☐ N.P. ☐ P.A. Phone _____

Primary Care Provider Location _____ Fax _____

Personal Email _____

Employer _____ ☐ Full ☐ P/T

Preferred Language _____ ☐ Interpreter Needed Religion _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Race/Physical Feature(s) ☐ American Indian ☐ Asian ☐ African American ☐ Pacific Islander ☐ White
☐ Other _____ ☐ Unknown ☐ Choose Not to Disclose

Ethnicity/Culture ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown ☐ Choose Not to Disclose

EMERGENCY CONTACTS

Primary Emergency Contact _____ Relationship to Patient _____

Primary Phone (____) _____ ☐ Home ☐ Cell ☐ Work ☐ Other _____

Secondary Phone (____) _____ ☐ Home ☐ Cell ☐ Work ☐ Other _____

Secondary Emergency Contact _____ Relationship to Patient _____

Primary Phone (____) _____ ☐ Home ☐ Cell ☐ Work ☐ Other _____

Secondary Phone (____) _____ ☐ Home ☐ Cell ☐ Work ☐ Other _____



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RESPONSIBLE PARTY (GUARANTOR)

☐ Same as Patient

Full Legal Name (Last, First, MI) _____ ☐ Jr. ☐ Sr. ☐ II ☐ III ☐ Other _____

Guarantor Relationship to Patient _____ SSN _____

Date of Birth _____ Legal Sex ☐ Male ☐ Female ☐ Decline to Answer

Physical Address (Required) _____ City/State/Zip _____

Mailing Address (If Different) _____ City/State/Zip _____

Preferred Phone (____) _____ ☐ Home ☐ Cell ☐ Work ☐ Other _____

Secondary Phone (____) _____ ☐ Home ☐ Cell ☐ Work ☐ Other _____

Personal Email _____

Employer _____ ☐ Full ☐ P/T

INSURANCE INFORMATION

Primary Insurance Company _____

Subscriber Name _____ SSN _____ Date of Birth _____

Address (if different from above) _____

City/State/Zip _____

Subscriber Number PCP _____ Effective Date _____ Group Number _____

Group/Employer Name _____

Physical Address _____ City/State/Zip _____

Secondary Insurance Company _____

Subscriber Name _____ SSN _____ Date of Birth _____

Address (if different from above) _____ City/State/Zip _____

Subscriber Number PCP _____ Effective Date _____ Group Number _____

Group/Employer Name _____

Physical Address _____ City/State/Zip _____

COMMUNICATION PREFERENCE

Check All That Apply ☐ MyChart ☐ Text ☐ Phone ☐ Mail

☐ Check here if you'd like for Carilion Clinic to provide information about our newest services, products and offerings.

You may opt out at any time.

Thank you for choosing Carilion Clinic.