9/2024

CARILION CLINIC

PATIENT INFORMATION FORM -- CONFIDENTIAL

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. ☐ D.O. ☐ 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

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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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PATIENT INFORMATION FORM -- CONFIDENTIAL

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.