CENTRAL OHIO PRIMARY CARE

PATIENT DEMOGRAPHIC INFORMATION - ADULT

Please Complete This Entire Form. Thank You!

Today's Date: _____/_____/____ **Referred By *(If Applicable)*: _____**

PATIENT INFORMATION

OFFICE USE (P#):

LAST NAME:	LEGAL FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH *(mm/dd/yyyy)*:
PREFERRED NAME:	HOME PHONE: ( )	CELL PHONE: ( )	PRIOR NAME(S):

GENDER IDENTITY: □ Male □ Female □ Female-to-Male (FTM) /Transgender Male/Trans Man
□ Male-to-Female (MTF) /Transgender Female/Trans Woman □ Genderqueer or Non-Binary
□ Choose not to disclose □ Something else, please describe:

GENDER PRONOUNS: □ she/her/hers □ he/him/his □ they/them/their □ Other: _____

SEX ASSIGNED AT BIRTH: □ Male □ Female □ Unknown

MARITAL STATUS: □ Single □ Married □Divorced □Widowed □ Separated

SEXUAL ORIENTATION:
□ Straight or Heterosexual □ Lesbian, Gay □ Bi-sexual □ Do not know □ Choose not to Disclose
□ Something else, please describe:

MAILING ADDRESS:	CITY:	STATE:	ZIP:
PHYSICAL ADDRESS *(If different from mailing address)*:	CITY:	STATE:	ZIP:

Preferred Pharmacy: Pharmacy Telephone: ( )

E-MAIL ADDRESS:	USE E-MAIL ADDRESS FOR PATIENT PORTAL:	SOCIAL SECURITY #:
□ None □ Prefer Not to Disclose	□ Yes □ No □ Not Applicable	

RACE: □ American Indian/Alaskan Native □ Asian □ Black/African American
□ Native Hawaiian/Other Pacific Islander □ White □ Refuse to Report □ Other

PREFERRED LANGUAGE: □ English □ Spanish
□ Other (*please specify*):
Translator Needed: □ Yes □ No

ETHNICITY: □ Hispanic/Latino
□ Non-Hispanic/Latino
□ Refuse to Report

CURRENT LEVEL OF CARE: □ Hospice
□ Permanent Nursing Facility (Long Term Care, Memory Care Unit) Facility Name:
□ Not Applicable

EMERGENCY CONTACT

LAST NAME:	FIRST NAME:	RELATIONSHIP *(Please specify)*:
HOME PHONE: ( )		CELL PHONE: ( )

PLEASE CONTINUE ON THE BACK SIDE OF THIS FORM

ADDITIONAL CONTACT (OPTIONAL)

LAST NAME:	FIRST NAME:	RELATIONSHIP *(Please specify)*:
HOME PHONE: ( )		CELL PHONE: ( )

EMPLOYER INFORMATION

EMPLOYER NAME:	EMPLOYER PHONE NUMBER: ( )
EMPLOYMENT STATUS: □ Employed □ Full Time □ Part Time □ Retired □ Self Employed □ Unemployed □ Active Military □ Student	

INSURANCE INFORMATION

(Please present all current insurance cards to the Front Desk)

I HAVE INSURANCE: □ Yes □ No *(Self Pay)*			
PRIMARY INSURANCE:		SECONDARY INSURANCE:	
SUBSCRIBER:	RELATION:	SUBSCRIBER:	RELATION:
SEX/GENDER with Insurance Company COPC recognizes your gender identity. For insurance/billing purposes, what sex/gender marker is on file with your insurance company? □ Male □ Female		SEX/GENDER with Insurance Company COPC recognizes your gender identity. For insurance/billing purposes, what sex/gender marker is on file with your insurance company? □ Male □ Female	
DATE OF BIRTH *(mm/dd/yyyy)*:	SOCIAL SECURITY #:	DATE OF BIRTH *(mm/dd/yyyy)*:	SOCIAL SECURITY #:

CONFIDENTIAL COMMUNICATION

(I hereby request to receive confidential communications from COPC in the following manner)

TELECOMMUNICATIONS –Please leave messages regarding my protected health information as follows (*Check Preferred*):	POSTAL COMMUNICATIONS –Please mail my protected health information to me at (*Select One*):
□ Home Phone of Record □ Brief □ Extended □ Cell Phone of Record □ Brief □ Extended □ Work Phone of Record □ Brief □ Extended Example of Extended: Lab Results Example of Brief: Time/Day of Appointment	□ Mailing Address of Record □ Street Address of Record □ Other: _____ Street Address City State Zip

ADVANCE DIRECTIVES

DO YOU HAVE A LIVING WILL? □ No □ Yes
(If yes, please provide a copy to the Front Desk)
DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE? □ No □ Yes
(If yes, please provide a copy to the Front Desk)
DO YOU HAVE A DO NOT RESCUSITATE? □ No □ Yes
(If yes, please provide a copy to the Front Desk)

HOW DID YOU HEAR ABOUT US?

□ Community Event □ COPC Website □ Facebook □ Health Plan Website □ Internet Search □ Online Reviews
□ Outdoor/ Billboard Advertisement □ Print Advertisement □ Radio Advertisement □ Television Advertisement
□ Referred by COPC Physician □ Referred from Friend/Family □ Other_____

FOR COPC SPECIALTY PATIENTS ONLY: PRIMARY CARE PROVIDER

Primary Care Provider: PHONE NUMBER: ( )

_____ Patient Printed Name
_____ Patient Signature
_____ Date Signed

_____ Legal Guardian Printed Name (*if applicable*)*
_____ Legal Guardian Signature (*if applicable*)*
_____ Date Signed