**Coastal Plains Integrated Health**

**Demographic Form**

Date: MRN:

Last Name First Name MI

Soc. Sec. # Date of Birth

Mailing Address

Home Address

Home Phone ( ) Cell Phone ( )

Employment Veteran (circle one) Yes No

Ethnicity Gender(circle one) M F

Marital Status Legal Status(circle one) Adult Minor (child under the age of 18)

Primary Care Physician Phone ( )

Address City

Allergies

Insurance (circle one) Yes No If Yes, type of Insurance

**EMERGENCY CONTACT:**

Name

Address City, State, Zip

Phone Number ( ) Relationship

**If applicant is a MINOR:**

Responsible Person

Address City, State, Zip

Phone Number ( ) Relationship

Parent’s/Guardian’s Work Phone ( )

Minor’s School Grade

**Participate in Patient Portal:** (circle one) Yes No

Email Address

Challenge Question (Last 4 digits of SSN)

**Copy of ALL Insurance Cards need to be given**

**To Front Desk Receptionist**