HIGH PLAINS
Primary Care

Patient Demographic Form
Please Print

Date:

****

Patient Information

Last Name First Name Middle Initial

Date of Birth Social Security # Sex

Marital Status Language (other than English) -

Race (optional) American Indian/Alaskan Native Asian/Pacific Islander Black-Non-Hispanic Hispanic White-Non-Hispanic Other

Home Address City and State Zip Code

Home Phone Cell Phone Work Phone

Email Address

****

Guarantor Information

Relationship to Patient: Self Spouse Parent Other

Last Name First Name Middle Initial

Date of Birth Social Security # Sex

Marital Status Language (other than English)

Race (optional) American Indian/Alaskan Native Asian/Pacific Islander Black-Non-Hispanic Hispanic White-Non-Hispanic Other

Home Address City and State Zip Code

Home Phone Work Phone Cell Phone

Email Address

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Emergency Contact Information

Full Name Relationship to Patient Phone#

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Insurance Information

*Please provide a copy of the front and back of your current insurance card(s)

Name of Insurance Carrier Patient Relationship to Subscriber

Subscriber Name Subscriber Social Security # Subscriber Date of Birth

Subscriber's Employer Employer's Phone #

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Secondary Insurance Information

Name of Insurance Carrier Patient Relationship to Subscriber

Subscriber Name Subscriber Social Security # Subscriber Date of Birth

Subscriber's Employer Employer's Phone