Patient Demographic Form

Please PRINT

Creighton UNIVERSITY Medical Center
Creighton Medical Associates

MRN **Date**

PATIENT INFORMATION

Last Name **First Name** **Middle Initial** **Nickname/AKA**

Date of Birth **Social Security Number** **Gender** ❑ Male ❑ Female

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Life Partner ❑ Separated ❑ Widowed ❑ Other **Language** other than English

Race (Optional) ❑ Black – Non Hispanic ❑ American Indian/ Alaskan Native ❑ Hispanic ❑ Asian/Pacific Islander ❑ White – Non Hispanic ❑ Other

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Email Address **Employment Status** ❑ Active Duty Military ❑ Employed Full-Time ❑ Not Employed ❑ Student Full-Time ❑ Child ❑ Employed Part-Time ❑ Retired ❑ Student Part-Time ❑ Disabled ❑ Homemaker ❑ Self Employed ❑ Other

Employer **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician **Referring Physician**

How did you hear about us? ❑ Billboard ❑ Friend ❑ Magazine ❑ Physician ❑ Website ❑ Other ❑ Employer ❑ Health Fair Event ❑ Mail ❑ Radio ❑ Yellow Pages ❑ Family Member ❑ Insurance ❑ News ❑ Television

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ❑ Self (If self, skip to Emergency / Next of Kin) ❑ Spouse ❑ Parent ❑ Other

Last Name **First Name** **Middle Initial**

Date of Birth **Social Security Number**

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Employer **Employment Status** ❑ Active Duty Military ❑ Employed Full-Time ❑ Not Employed ❑ Student Full-Time ❑ Child ❑ Employed Part-Time ❑ Retired ❑ Student Part-Time ❑ Disabled ❑ Homemaker ❑ Self Employed ❑ Other

Employer Phone

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name **First Name** **Relationship to Patient**

Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

OTHER CONTACT INFORMATION – NOT LIVING WITH PATIENT

Last Name **First Name** **Relationship to Patient**

Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

- **If copies of insurance cards are not attached, please complete Patient Insurance Form**
- **Fax completed form and insurance cards to Registration Services at 280-3989**