

## FLI Demographic Form

\_\_\_\_\_  
Patient Name (Last, First, Middle)

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Street

\_\_\_\_\_  
Patient Phone (Home)

\_\_\_\_\_  
Patient Phone (Work)

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Patient Phone (Cell)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Sex

Race:  African/African American  
 Native American/Alaskan

Caucasian/European American  
 Native Hawaiian/other Pacific Islander

Asian/Asian American  
 Other Race

Ethnicity:  non-Hispanic  Hispanic  not specified

E-mail address: \_\_\_\_\_

Preferred method of contacting you:  e-mail  phone (Circle: home, work or cell)

\_\_\_\_\_  
Name of nearest relative

\_\_\_\_\_  
Relative Phone (Home)

\_\_\_\_\_  
Relative Phone (Work)

May we discuss your medical condition with someone else? (Name) \_\_\_\_\_

Whom may we thank for your referral here? \_\_\_\_\_

### GUARANTOR

\_\_\_\_\_  
Person responsible for payment

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Street address

\_\_\_\_\_  
Guarantor Phone (Home)

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Guarantor's employer

\_\_\_\_\_  
Employer Phone (Work)

\_\_\_\_\_  
Employer's address

\_\_\_\_\_  
Spouse's name