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 Marital Status

E-mail: _____

Pharmacy name:_____

Pharmacy address: _____

Pharmacy phone number: _____

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

Race: __African/African American __Caucasian/European American __Asian/Asian American
__Native American/Alaskan __Native Hawaiian/other Pacific Islander __Other Race

Ethnicity: __non-Hispanic __Hispanic __not specified

_____ _____ _____
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? _____

INSURANCE INFORMATION

_____ _____ _____
Person responsible for payment (Guarantor) Social Security Number Relationship

_____ _____
Street address Guarantor's Phone (Home)

_____ _____
City, State, Zip Guarantor's Date of Birth

_____ _____
Guarantor's employer Employer's Phone

_____
Employer's address (including city, state, zip)