NORTHERN
Cardiology
a department of Northern Regional Hospital

PATIENT DEMOGRAPHIC INFORMATION

PATIENT NAME: _____ _____ _____ _____
LAST FIRST MIDDLE MAIDEN

SEX (CIRCLE ONE): M / F BIRTHDATE: ____/____/____ AGE: _____ SOCIAL SECURITY # _____-_____-_____

RACE: ____ CAUCASIAN (WHITE) ____ BLACK/AFRICAN AMERICAN ____ NATIVE AMERICAN/ALASKAN
____ ASIAN ____ HISPANIC/LATINO ____ MIDDLE EASTERN
____ PACIFIC ISLANDER ____ OTHER: _____
____ MIXED RACE: _____ ____ REFUSE TO REPORT OR UNKNOWN

ETHNICITY: _____HISPANIC OR LATINO _____AMERICAN ____ OTHER _____
_____REFUSE TO REPORT OR UNKNOWN

LANGUAGE PREFERENCE: ____ENGLISH ____SPANISH ____JAPANESE ____GERMAN ____HINDI ____GREEK
____ CHINESE ____ OTHER:_____

ADDRESS: _____ CITY: _____ STATE: _____ZIP:_____

TELEPHONE: HOME _____ WORK _____ CELL _____

EMAIL ADDRESS: _____@_____ Decline to give email

EMPLOYER NAME: _____ PHONE: _____

SPOUSE'S NAME: _____ SPOUSE'S SS#: _____-_____-_____

SPOUSE'S DATE OF BIRTH: _____/_____/_____ CELL PHONE NUMBER: _____

REFERRING PHYSICIAN NAME: _____ PHONE _____

EMERGENCY INFORMATION

NAME: _____PHONE: _____
(SOMEONE NOT LIVING AT SAME ADDRESS WITH YOU)

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

PHARMACY INFORMATION

PREFERRED PHARMACY NAME: _____ PHONE: _____

DURABLE MEDICAL EQUIPMENT INFORMATION (IF USED)
(CPAP, OXYGEN, NEBULIZERS OR OTHER EQUIPMENT/SUPPLIES)

COMPANY NAME: _____ PHONE: _____

PLEASE SIGN HERE AFTER COMPLETING FORM:

PATIENT SIGNATURE _____ DATE:_____/_____/_ _____

PARENT / GUARDIAN (FOR MINORS OR POA) _____ DATE: _____/_____/_____

SMS-07