Today's Date

Patient Information

Last Name ______________________

First Name ______________________

First Name Used ______________________

Middle Name ______________________

Former Last Name ______________________

Legal Sex ______________________

Gender Identity
- ☐ Male ☐ Female
- ☐ Transgender FTM
- ☐ Transgender MTF
- ☐ Gender non-conforming
- ☐ Choose not to disclose
- ☐ Other, Please specify:______________

Assigned Sex at Birth
- ☐ Male ☐ Female
- ☐ Choose not to disclose
- ☐ Unknown

Preferred Pronouns
- ☐ he/him ☐ she/her
- ☐ they/them

DOB ______________________

Address ______________________

Address 2 ______________________

City ______________________

State ______________________

Zip ______________________

Home phone ______________________

Mobile phone ______________________

Work phone ______________________

Contact preference HOME MOBILE WORK

May we text you? YES NO

Email (required) ______________________

Preferred Pharmacy ______________________

Preferred Lab ______________________

Preferred Radiology ______________________

Primary Care Physician ______________________

Marital Status ______________________

Homebound YES NO

Language ______________________

Race ______________________

Ethnicity ______________________

Guardian

Last Name ______________________

First Name ______________________

Middle name ______________________

Emergency Contact

Name ______________________

Relationship ______________________

Home phone ______________________

Mobile phone ______________________

Next of Kin

Name ______________________

Relationship ______________________

Phone ______________________

Employment

Employer name ______________________

Employer phone ______________________

How did you hear about us?
- ☐ Referred by Friend or Relative:______________
- ☐ Referred by Another Doctor:______________
- ☐ Privia Provider Online Directory
- ☐ Insurance company
- ☐ Advertisement
- ☐ Online Search
- ☐ Other, Please specify:______________

Primary Insurance Information

Insurance Plan Name ______________________

ID/Certification No. ______________________

Policy/Group No. ______________________

Primary Policy Holder (if other than patient)

Patient's Relationship to policy holder: ______________________

Last Name ______________________

First Name ______________________

Middle Name ______________________

Address ______________________

Address (ctd) ______________________

City ______________________

State ______________________

Zip ______________________

Date of Birth ______________________

Policy Holder Sex ______________________

Employer Name ______________________

Secondary Insurance Information

Insurance Plan Name ______________________

ID/Certification No. ______________________

Policy/Group No. ______________________

Secondary Policy Holder (if other than patient)

Patient's Relationship to policy holder: ______________________

Last Name ______________________

First Name ______________________

Middle Name ______________________

Address ______________________

Address (ctd) ______________________

City ______________________

State ______________________

Zip ______________________

Date of Birth ______________________

Policy Holder Sex ______________________

Employer Name ______________________

Guarantor Information

Last Name ______________________

First Name ______________________

Middle name ______________________

DOB ______________________

Address ______________________

Address 2 ______________________

City ______________________

State ______________________

Zip ______________________

Optional Information

Phone ______________________

Patient Signature: ______________________________ **Date:** ______________