SOUTHWEST VIRGINIA COMMUNITY HEALTH SYSTEMS, INC.

PATIENT DEMOGRAPHIC FORM

PERSONAL INFORMATION: NAME: ____ First Middle Last ADDRESS:___ PO BOX / STREET CITY STATE ZIP TELEPHONE: HOME CELL____OTHER__ EMAIL ADDRESS: DATE OF BIRTH:_____ SEX: Male____ Female___ MARITAL STATUS: Single_____ Married_____ Divorced____ Other____ SOCIAL SECURITY NUMBER: STUDENT: Full -Time___ Part -Time___ No___ RACE: American Indian or Alaskan Native _____ Asian ____ Black or African American ____ Native Hawaiian or other Pacific Islander ____ White ____ More than one race ____ Refused to respond _____

ETHNICITY: Hispanic _____ Non-Hispanic _____ Refused to respond _____

RESPONSIBLE PERSON FOR PAYMENT:

NAME:	PHONE:
ADDRESS:	
RELATIONSHIP TO PATIENT:	

EMPLOYMENT INFORMATION:

EMPLOYER NAME:		
EMPLOYER ADDRESS:		
EMPLOYER PHONE NUMBER:		
EMPLOYMENT STATUS: Full-time	Part-time	Unemployed

\$15,001 - \$20,000 \$20,001 - \$25,000 \$25,001 - \$30,001 - \$35,001 - \$35,001 - \$35,001 - \$40,000 \$40,001 - \$45,000 \$45,001 - \$45,	FINANCIAL INFORMATION - RANGE OF	INCOME PER YEAR:#	of Dependents
NAME: ADDRESS: TELEPHONE NUMBER: RELATIONSHIP TO PATIENT: INSURANCE INFORMATION: INSURANCE NAME: SUBSCRIBER NAME: SUBSCRIBER ID# GROUP #	\$15,001 - \$20,000 \$30,001 - \$35,000 \$45,001 - \$50,000	\$20,001 - \$25,000 \$35,001 - \$40,000 \$50,001 - \$55,000	\$10,001 - \$15,000 \$25,001 - \$30,000 \$40,001 - \$45,000 \$55,001 - \$60,000 \$75,001 or higher
TELEPHONE NUMBER: TELEPHONE NUMBER: RELATIONSHIP TO PATIENT: INSURANCE INFORMATION: INSURANCE NAME: SUBSCRIBER NAME: SUBSCRIBER ID# GROUP #	EMERGENCY CONTACT:		
TELEPHONE NUMBER: RELATIONSHIP TO PATIENT: INSURANCE INFORMATION: INSURANCE NAME: SUBSCRIBER NAME: SUBSCRIBER ID# GROUP #	NAME:		
INSURANCE INFORMATION: INSURANCE NAME: SUBSCRIBER NAME: SUBSCRIBER ID# GROUP #	ADDRESS:		
INSURANCE INFORMATION: INSURANCE NAME: SUBSCRIBER NAME: SUBSCRIBER ID# GROUP #	TELEPHONE NUMBER:		
INSURANCE NAME: SUBSCRIBER NAME: SUBSCRIBER ID# GROUP # EFF. DATE	RELATIONSHIP TO PATIENT:		
SUBSCRIBER NAME: SUBSCRIBER ID# GROUP #	INSURANCE INFORMATION:		
SUBSCRIBER ID# GROUP # EFF. DATE INSURANCE PROVIDED BY EMPLOYER? Yes No IS PATIENT COVERED BY INSURANCE? Yes No PATIENT RELATIONSHIP TO SUBSCRIBER: SECONDARY INSURANCE (if applicable) SUBSCRIBER NAME: ID# GROUP # EFF. DATE PHARMACY PHONE ADDRESS Patient (or)	INSURANCE NAME:		
GROUP #	SUBSCRIBER NAME:		
INSURANCE PROVIDED BY EMPLOYER? Yes	SUBSCRIBER ID#		
IS PATIENT COVERED BY INSURANCE? Yes	GROUP #	EFF. DATE	
PATIENT RELATIONSHIP TO SUBSCRIBER: SECONDARY INSURANCE (if applicable) SUBSCRIBER NAME: GROUP # EFF. DATE PHARMACY PHONE ADDRESS Patient (or)	INSURANCE PROVIDED BY EMPLOYER	? YesNo	
SECONDARY INSURANCE (if applicable) SUBSCRIBER NAME: ID# GROUP # EFF. DATE PHARMACY PHONE ADDRESS Patient (or)	IS PATIENT COVERED BY INSURANCE?	YesNo	
SUBSCRIBER NAME: ID#	PATIENT RELATIONSHIP TO SUBSCRIB	ER:	
GROUP #	SECONDARY INSURANCE (if applicable)		
PHARMACYPHONE ADDRESS Patient (or)	SUBSCRIBER NAME:	ID#	
ADDRESSPatient (or)	GROUP #	EFF. DATE	
Patient (or)	PHARMACY	PHONE	
	ADDRESS		
	Patient (or)		
Guardian Signature Date:			_ Date:

revised 09/11/2014