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_____

FINANCIAL INFORMATION - RANGE OF INCOME PER YEAR: ____# of Dependents

_____ $0 - $5,000	_____ $5,001 - $10,000	_____ $10,001 - $15,000
_____ $15,001 - $20,000	_____ $20,001 - $25,000	_____ $25,001 - $30,000
_____ $30,001 - $35,000	_____ $35,001 - $40,000	_____ $40,001 - $45,000
_____ $45,001 - $50,000	_____ $50,001 - $55,000	_____ $55,001 - $60,000
_____ $65,001 - $70,000	_____ $70,001 - $75,000	_____ $75,001 or higher

EMERGENCY CONTACT:

NAME:_____

ADDRESS:_____

TELEPHONE NUMBER:_____

RELATIONSHIP TO PATIENT: _____

INSURANCE INFORMATION:

INSURANCE NAME:_____

SUBSCRIBER NAME:_____

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)
Guardian Signature_____ Date:_____