Salisbury Pediatric Associates, PA

Date:_____

Pt. ID #:_____

Salisbury Pediatric Associates

Annual Patient Information Sheet

Adults– 18 years & older

Patient's Legal Name:_____ ____ _____

(First Name) (MI) (Last Name)

Patient's Preferred Name:_____Date of Birth:_____ SS#:_____

Address:_____

(Street Address / PO Box) City State Zip

Primary Phone #:(_____)_____-_____ Alternate Phone #:(_____)_____-_____

Place of Employment:_____ Work Phone #(_____)-_____-_____

Race (check One):

O American Indian/ Alaska Native O Black/African American

O Native Hawaiian O Other Pacific Islander

O Asian O White

O More than 1 race O Declines to Respond

Gender (check one) : Ethnicity (check one):

O Male O Female O Hispanic or Latino O Not Hispanic or Latino

Preferred Language:_____ Preferred Physician:_____

Preferred Notification Method: O Portal message O Phone O Mail

Preferred Email Address:_____

INSURANCE INFORMATION

****PLEASE NOTE THAT YOU WILL BE ASKED FOR YOUR INSURANCE CARD AT EVERY VISIT****

IF YOU ARE UN-INSURED OR WE ARE UNABLE TO VERIFY YOUR INSURANCE, YOU WILL BE RESPON-

EMERGENCY CONTACTS

Name:_____ Relationship:_____

Home Phone:_____Cell Phone:_____ Work Phone:_____