BAY AREA INFECTIOUS DISEASE ASSOCIATES

2023 Demographic Sheet

DEMOGRAPHIC DETAILS (To be completed annually)

Name: ____________________________________ **DOB:** _______________ **Gender:** ________

SSN: ___________________ **Marital Status:** ________________ **Preferred Language:** __________________

Home Phone: ______________________ ☐ Preferred **Cell Phone:** _________________________ ☐ Preferred

Address: ____

Street Address | Apt/Unit # | City | State | Zip Code

Email Address: __________________________________

I would like my log information to the patient portal sent to the email address above. ☐ **Yes** ☐ **No**

Race: ☐ **American Indian/Alaska Native** ☐ **Asian** ☐ **Black/African American**
☐ **Caucasian** ☐ **Native Hawaiian/Other Pacific Islander** ☐ **Other:** _______________

Ethnicity: ☐ **Hispanic/Latino** ☐ **Non-Hispanic/Latino**

Emergency Contact: ______________________________ **Relationship:** __________ **Phone :**______________

Advanced Directives: ☐**Yes, on file with PCP** ☐**Yes, on file with hospital** ☐ **Yes, DNR** ☐**None**

Primary Care Physician: _____________________________________ **Phone #:** _____________________

Referring Provider: ____ **Phone #:** _____________________

Preferred Pharmacy: ____ **Phone #:** _____________________

INSURANCE INFORMATION – We kindly ask for your card to scan into our system.

☐ **Primary** ☐ **Secondary**

Insurance Company: _________________________

ID#: ___________________________

Group #: _______________________

Policy Holder's Name: ______________________

DOB: __________ Relationship: ________

SSN: ____________________

☐ **Primary** ☐ **Secondary**

Insurance Company: _________________________

ID#: ___________________________

Group #: _______________________

Policy Holder's Name: ______________________

DOB: __________ Relationship: ________

SSN: ____________________