Lubbock
PRIMARY CARE
VIP Medicine

PATIENT DEMOGRAPHIC INFORMATION

_____ **DOB:** _____/_____/_____ **SSN:** _____
LAST **FIRST** **MIDDLE INITIAL**

MAILING ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME TELEPHONE: (**)** _____ **CELL PHONE: (** **)** _____

EMPLOYMENT STATUS: □ EMPLOYED □ STUDENT □ RETIRED □ OTHER

EMPLOYER: _____ **WORK NUMBER: (** **)** _____ **EXT:** _____

EMAIL: _____**@**_____**. COM** **GENDER:** □ MALE □ FEMALE

PREFERRED PHARMACY (ADDRESS/CROSSING INTERSECTION): _____

MARITAL STATUS: □ SINGLE □ MARRIED □ WIDOWED □ SEPERATED □ DIVORCED

PREFERRED LANGUANGE: □ ENGLISH □ SPANISH □ SIGN □ OTHER: _____

ETHNICITY: □ HISPANIC, LATINO, OR OF SPANISH ORIGIN □ NOT HISPANIC, LATINO, OR OF SPANISH ORIGIN □ REFUSE

RACE: □ BLACK/AFRICAN AMERICAN □ CAUCASIAN/WHITE □ HISPANIC □ NATIVE AMERICAN/ALASKAN NATIVE
□ NATIVE HAWAIIAN/PACIFIC ISLANDER □ ASIAN

EMERGENCY CONTACT: _____ **TELEPHONE: (** **)** _____

EMERGENCY CONTACT RELATIONSHIP: _____

WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS: □ YES □ NO

PRIMARY CARE PHYSICIAN: _____ **OB/GYN** *(if applicable)* _____

GUARANTOR/INSURANCE SUBSCRIBER INFORMATION *(if patient is under 18)*

GUARANTOR NAME: _____ **RELATIONSHIP TO PATIENT:** _____

DOB: _____/_____/_____ **MAILING ADDRESS:** _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME/CELL TELEPHONE: (**)** _____ **SSN:** _____

GUARANTOR'S EMPLOYER: _____ **WORK NUMBER: (** **)** _____

TELEPHONE CONSUMER PROTECTION ACT

By providing us with a telephone number for a wireless device, you agree that for us and/or our service providers to service your account(s) including, but not limited to, contacting you about obtaining potential financial assistance for your account(s) or to collect any amounts you may owe, we, our agents, representatives, or other service providers may contact you at the above listed telephone number(s) which could result in charges to you from your telephone service provider. You expressly consent that methods of contact may include using pre-recorded and artificial voice messages and/or the use of an automatic dialing device, as applicable. This consent applies to all services and billing associated with your account(s) and is not a condition of purchasing property, goods, or services. You are not required to sign this consent as a condition of treatment. *In addition, LUBBOCK PRIMARY CARE respects the strict confidentiality of the physician-patient relationship and we ask you to do the same. By signing below, you agree that you will not record any person within LUBBOCK PRIMARY CARE (inclusive of its affiliated physicians, other healthcare providers, and/or staff) without their expressed written consent.* ***Initials*** _____

_____ _____ _____
Patient Name *(printed)* **Patient/Guardian/Legal Representative Signature** **Date**

_____ _____ _____
Witness Name *(printed)* **Witness Signature** **Date**