

**Somerset Health Services
Patient Demographic Collection Sheet**

Patient Name: _____ Patient Social Security #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cellphone: _____

Sex (*circle one*): Male Female Date of Birth: _____

Marital Status (*circle one*): Single Married Widowed Separated Divorced

Email Address (if over the age of 18): _____

Primary Care Physician/Referring Physician: _____

Employment Status (*circle one*): Disabled Not Employed Retired Full Time Part Time Student

Race (*circle one*): White Asian American Indian/Alaskan Native Black/African American
Native Hawaiian More than One Race Other Pacific Islander Prefer not to Report

Ethnicity (*circle one*): Not Hispanic or Latino Hispanic or Latino Prefer not to Report

Primary Language (*circle one*): English Spanish Other: _____

If patient is under the age of 18, complete this section.

Legal Mother's Name: _____ Legal Mother's Phone: _____

Legal Father's Name: _____ Legal Father's Phone: _____

Guarantor Information (the guarantor is the person responsible for paying the bill)

Guarantor Name (must be a parent or guardian if under age 18): _____

Guarantor Social Security #: _____ Guarantor Date of Birth: _____

Subscriber Information (the subscriber is the person who is the policy holder)

Is the patient the policy holder for the health insurance coverage? Yes / No If yes, skip this section.

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder Date of Birth: _____ Policy Holder Social Security #: _____

Emergency Contact Information

Name of Emergency Contact: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____