Barry Pointe Family Care A Division of Signature Medical Group, KC
Patient Information

Patient Name _____ **Nickname: _____**

Social Security Number _____ **Patient ID#_____**

Address: **City:** **State:** **Zip code:** **Preferred Phone number:** **Can messages be left on the phone? Y N**	**Date of Birth:** **Age:** **Sex at Birth:** M F **Gender Identity** M F **Sexual Orientation**: o Straight/heterosexual o Gay /Homosexual o Bisexual o Other: _____ **Marital Status**: Married Divorced Separated Widowed Single Other:_____
Alternate Phone Number: **Can messages be left on this phone? Y N**	**Emergency Contact:** **Name: _____** **Relationship: _____** **Phone Number: _____** **Can messages be left on this phone? Y N**
*******IF EMERGENCY CONTACT LISTED PLEASE**	**MAKE SURE THEY ARE ADDED TO YOUR HIPAA FORM**************
Demographics: **Race:** o **White/Caucasian** o **Black/African American** o **Asian** o **Hispanic** o **Native American** o **Multiracial** o **Other _____**	**Ethnicity:** o **Non-Hispanic** o **Hispanic** o **Other/Unknown** **Preferred Language:** o **English** o **Spanish** o **Other: _____**
Are you hearing impaired? Y N **Do you require an interpreter?** Y N	**Are you a Veteran?** Y N
Employer:	**Occupation:** **Part-Time:** ☐ **Full-Time:** ☐
Email:	**Preferred Pharmacy:**

Signature of Patient or Legal Representative confirming above information is correct:

Name:_____ Date: _____