ATLAS
MEDICAL SYSTEMS, PLLC

Patient Demographic Information

Today's Date _____ How did you hear about us? _____

Patient Information

First Name _____ Last Name _____ M.I. ___
Male __ Female __ Date of Birth __/__/____ Age ___ Social Security # ___/__/___
Single __ Married __ Domestic Partner __ Divorced __ Widowed __
Physical Address _____ City _____ State ___ Zip Code _____
(If different)
Mailing Address _____ City _____ State ___ Zip Code _____
Home Phone # _____ Cell Phone # _____ Work Phone # _____
Email _____ Preferred Method of Contact _____
Employer _____ Contact # _____
Address _____ City _____ State ___ Zip Code _____

Optional race and ethnicity Information:

Race:

White __ Black or African American __ American Indian or Alaska Native __ Asian __ Native Hawaiian or Other Pacific Islander __ Decline to Provide __

Ethnicity:

Hispanic or Latino __ Not Hispanic or Latino __ Decline to Provide __
Emergency Contact _____ Contact # _____

Insurance:

Primary Insurance _____ ID # _____
Effective Date __/__/____
Secondary Insurance _____ ID # _____
Effective Date __/__/____

Responsible Party: Self ___
Name _____ Relationship _____
Date of Birth __/__/____ Social Security ___/__/___ Contact # _____
Address _____ City _____ State ___ Zip Code _____
Employer _____ Contact # _____

Patient/Responsible Party Signature _____ Date_____
Patient/Responsible Party Printed Name_____