LOTSU DIGESTIVE
HEALTH & NUTRITION

PATIENT DEMOGRAPHIC

Name: _____**DOB:** ___/___/___**Date:** ___/___/___

Address: _____

City: _____ **State:** _____ **Zip Code:** _____
SS#_____

Home Phone: _____**Cell Phone:** _____**Work Phone:** _____

Email Address: _____ **Referred by:** _____

Language: _____**Race:** _____

Sex: ○ **MALE** ○ **FEMALE** ○ **TRANSGENDER**

Marital Status: ○ **SINGLE** ○ **MARRIED** ○ **LIFE PARTNER** ○ **DIVORCED** ○ **WIDOWED**

Emergency Contact: _____

Relation: _____ **Phone:** _____

Primary Care Physician:
_____

Pharmacy: _____ **Address:** _____

Phone: _____

Insurance plan name: **Member ID:**

Group #:

Relation to Insured: ○ **SELF** ○ **SPOUSE** ○ **PARENT**

May we leave normal test results on your voicemail? ○ YES ○ NO

May we discuss results with another family member or friend? ○ YES ○ NO

IF YES, Whom? _____

How did you hear of our office? _____

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***I understand that it is my responsible for all charges for services provided including the balance remaining after possible instance payments. I understand that any co-payments are due at the time of my appointment. I authorize the release of any medical information necessary to process the claim.

Patient Signature: _____ Date: _____