DHAMY SIVAMOHAN, MD
PHONE: (812)752-4001
WEB: WWW.FMA-PC.COM

Patient Demographic Information

*Fields with * are required*

PATIENT INFORMATION

Last name*: _____ **First name*:** _____ **Middle initial:** _____

If minor, name of responsible parent: _____

Name you would like to appear on your health records: _____

What are your pronouns: ☐ He/him ☐ She/her ☐ They/them ☐ Other: _____

DOB*: _____ **Social Security#*:** _____ **Drivers license #*:** _____

Home address*: _____ **APT/suite #:** _____

City*: _____ **State*:** _____ **ZIP*:** _____

Pick one: **Home #*:** ☐ _____ **Mobile #*:** ☐ _____ (Checkmark the best number to use)

Email address*: _____

Do you think of yourself as:

☐ Male ☐ Female ☐ Transgender man/trans man ☐ Transgender woman/trans woman
☐ Genderqueer/gender nonconforming, neither exclusively male nor female
☐ A category not listed here, please specify: _____ ☐ Decline to answer

Do you think of yourself as:

☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual and/or questioning
☐ An orientation not listed here, please specify: _____ ☐ Don't know ☐ Decline to answer

Occupation: _____

Employer: _____

Phone #: _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

EDUCATION, LANGUAGE & DEMOGRAPHICS

Highest level of education: _____

Preferred language: _____ **Do you need an interpreter?:** _____

Ethnicity: _____ **Race:** _____

IF APPLICABLE, NAME OF SPOUSE/DOMESTIC PARTNER

Last name: _____ **First name:** _____ **Middle initial:** _____

IF THE PATIENT IS LIVING IN A NURSING OR ASSISTED LIVING FACILITY*

Name of facility*: _____

Address*: _____ **Room #*:** _____

City*: _____ **State*:** _____ **ZIP*:** _____

CONTACT INFORMATION FOR RESPONSIBLE PARTY/SPOUSE/PARENT (If info same as above, leave blank)

Last name: _____ **First name:** _____ **Middle initial:** _____

Social security #: _____ **Relationship to patient:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Home #: _____ **Cell #:** _____ **Email address:** _____

PATIENT REFERRAL INFORMATION			
Patient referred by*			Phone #
Address	City	State	ZIP
Primary care physician*			Phone #
Address	City	State	ZIP

EMERGENCY CONTACTS (PLEASE PROVIDE TWO WITH DIFFERENT CONTACT INFORMATION)			
Name	Relationship		Phone #
Address	City	State	ZIP
Name	Relationship		Phone #
Address	City	State	ZIP

Who can we share your information with?

Patient signature: _____ **Date:** _____

Patient representative/parent: _____ **Date:** _____

For patients requiring translation or verbal reading of the document, the reader or translator may document and sign below.

Reader/translator: _____ **Date:** _____

Billing Information & Responsible Party/Insurance Information

Last name: _____ **First name:** _____ **Middle initial:** _____

INSURANCE INFORMATION	
Primary insurer*	**Name of insured***
Insurance ID# / Group # / Other information	
Secondary insurer*	**Name of insured***
Insurance ID# / Group # / Other information	
Tertiary insurer*	**Name of insured***
Insurance ID# / Group # / Other information	
Pharmacy insurer*	**Name of insured***
Insurance ID# / BIN # / PCN # / Group # / Other information	

Patient signature: _____ **Date:** _____

For office use only:

Physician to be seen _____ **Date:** _____

Account number assigned: _____ **Initials:** _____