Code: EDL002

PATIENT DEMOGRAPHICS

USING THE TABLET

TO SCROLL UP/DOWN THE FORM, PLACE YOUR FINGER ON THE SCREEN OF THE TABLET AND SLIDE YOUR FINGER UPWARD OR DOWNWARD.

THE KEYBOARD *if no keyboard is available*

- TAP **INSIDE** A BOX. THIS WILL BRING UP THE KEYBOARD.
- TAP ANYWHERE OUTSIDE OF THE KEYBOARD TO HIDE IT

First Name ______________________ Middle Name / MI ______________________ Last Name ______________________

IF YOU ARE A RETURNING PATIENT, MANY OF THE FIELDS WILL ALREADY BE COMPLETED AUTOMATICALLY. PLEASE REVIEW CAREFULLY FOR ACCURACY. CHANGE ONLY IF NECESSARY.

ARE YOU (TAP ON A CIRCLE TO MAKE YOUR SELECTION)

○ A RETURNING PATIENT ○ A NEW PATIENT

TODAY'S DATE

____

REASON FOR VISIT

____

PATIENT INFORMATION

Date of Birth ______________________ Sex ______________________ Social Security Number ______________________

Ethnicity ______________________ Race ______________________

Patient Address Line 1 ______________________ Patient Address Line 2 ______________________

City ______________________ State ______________________ Zip ______________________

Home Phone Cell Phone Email

Patient Smoking Status

____

Other Tobacco

____

EMPLOYMENT STATUS

Patient Employment Status

____

Professional Title

____

Employer Name

____

WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY?

Emergency Contact Name

____

Emergency Contact Relationship to Patient

____

Emergency Contact Home Phone

____

Emergency Contact Cell Phone

____

Emergency Contact Work Phone

____

TO CONTINUE TO THE NEXT FORM, PLEASE CLICK ON THE GREEN NEXT BUTTON BELOW.

TO GO BACK TO THE PREVIOUS FORM, PLEASE CLICK ON THE RED BACK BUTTON BELOW (YOU WILL LOSE ALL INFORMATION IF YOU GO BACK)