

# 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)**