Patient Demographics
Capital Family Physician, P.A.

2417 Atrium Drive, Suite 201, Raleigh, N.C. 27607 Ph:919-232-0020 Fax:919-232-0030

Patient Information

□ Mr. □ Mrs. □ Ms. Last Name: _____ First Name: _____ Middle Initial: _____
Race:_____Ethnicity_____Preferred Language_____

Social Security Number: ____ - ____ - ____ Martial Status S M D W O Date of Birth: ___/__/__

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number/s:
Home: (_____) _____ - _____ Work: (_____) _____ - _____ Cell: (_____) _____ - _____

Email Address/s:
Home: _____ Work: _____
Employer Name:_____ Address:_____

In Case of Emergency, Notify: Name: _____

Day Time Phone (_____) – _____ - _____ Mothers Maiden Name: _____

Health Insurance

Primary:_____Secondary:_____

Guarantor Name (name on insurance card)

□ Mr. □ Mrs. □ Ms. Last Name: _____ First Name: _____ Middle Initial:_____

Social Security Number: _____ - ____ - _____ Date of Birth: _____ / _____ / _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number/s:
Home: (_____) _____ - _____ Work: (_____) _____ - _____ Cell: (_____) _____ - _____

Employer Name & Address: _____

Relationship to Patient: _____

Authorization To Release Medical Information

I authorize that my medical information can be left on my answering machine at home. YES _____ NO _____
I authorize that my medical information can be left on my voice mail at work. YES_____ NO _____

I want to be contacted by: Phone: Home _____ Work _____ Both _____
Voice Mail:_____ Email:_____
Spouse:(Name)_____ Other_____

Signature: _____ Date: _____