Patient Demographic Information

Please complete both pages of this form (page 1 and 2)

Titanium HEALTHCARE

HOW DID YOU HEAR ABOUT US?

PATIENT INFORMATION

Last name | First name | Middle initial (s)

Date of birth | Gender | SSN

Primary Care Provider name (if ***not*** Titanium) | Primary Care phone number | Primary Care Fax number

Preferred language | Race | Ethnicity

Advance Directive type | Name of preferred pharmacy

CONTACT INFORMATION

Street address | City | State | Zip code

Home phone number | Cell phone number | Work phone number

Email address

Communication preference (please check one)

☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email

PHARMACY INFORMATION

Pharmacy street address | City | State | Zip code

Pharmacy phone number | Pharmacy Fax number

Titanium HEALTHCARE

INSURANCE INFORMATION

Primary insurance

Effective date

Group #

Subscriber #

Office co-pay $

Deductible $

Name of insured

Relationship to patient

Insured employer's name

Employer phone

Employer address

Secondary insurance

Effective date

Group #

Subscriber #

Office co-pay $

Deductible $

Name of insured

Relationship to patient

Insured employer's name

Employer phone

Employer address

EMPLOYMENT INFORMATION

Employer name

Employer phone

Street address

City

State

Zip code

EMERGENCY CONTACT

Emergency contact name

Relationship to patient

Street address

City

State

Zip code

Home phone number

Cell phone number

Work phone number