GERIATRIC & MEDICAL SPECIALISTS OF MICHIGAN

PATIENT INFORMATION

Patient Name:_____Gender: Male_____Female_____

Address:_____City_____State_____Zip_____

Preferred Pharmacy: _____ Location: _____

Email: _____ Would you like access to your records through our secure patient web portal? _____ Yes _____No

Are you a Veteran or a family member of a Veteran? Yes_____ No _____

Main Phone:_____-_____-_____ (Cell or Land Line) Work Phone:_____

Social Security # _____-_____-_____ Birthdate: _____/_____/_____

Do you have an Advance Directive? (Living Will) Yes ____ No ____ Authorized Power of Attorney? Yes _____ No _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____
Race: ___ White ___ African/American **Are you**? ___ Hispanic ___ Non-Hispanic
Spouse's Name _____ Date of Birth _____
Other Household Members: _____

Employer:_____Occupation: _____

Primary Insurance: _____

Contract Number: _____Group Number: _____

Secondary Insurance: _____

Contract Number: _____Group Number: _____

Emergency Contact Name: _____Relation: _____

Emergency Contact Address: _____ _____

Emergency Contact Phone Number: _____-_____-_____

Are you responsible for your own finances? Yes ____ No _____

If no, who is? _____ Phone #: _____-_____-_____

Address: _____

Do you need assistance with transportation to your medical appointments? _____ Yes or _____ No