Barry Pointe Family Care – A Division of Clay Platte Family Medicine
Patient Information:

Patient Name: _____ **Nickname:** _____

Social Security Number: _____ **Patient ID#** _____

Address: **City:** **State:** **Zip Code:** **Preferred Phone Number:** **Can messages be left on the phone? Y N**	**Date of Birth:** **Age:** **Sex at Birth: M F** **Gender Identity: M F** **Sexual Orientation:** ○ **Straight/Heterosexual** ○ **Gay/Homosexual** ○ **Bisexual** ○ **Other:** _____ **Marital Status:** Married Divorced Separated Widowed Single **Other:** _____
Alternate Phone Number: **Can Messages be left on this phone? Y N**	**Emergency Contact:** **Name:** _____ **Relationship:** _____ **Phone Number:** _____ **Can messages be left on this phone? Y N**
*****IF EMERGENCY CONTACT LISTED, PLEASE MAKE SURE THEY ARE ADDED TO YOUR HIPAA FORM*****	
Demographics: **Race:** ○ **White/Caucasian** ○ **Black/African American** ○ **Asian** ○ **Hispanic** ○ **Native American** ○ **Multiracial** ○ **Other:** _____	**Ethnicity:** ○ **Non-Hispanic** ○ **Hispanic** ○ **Other/Unknown** **Preferred Language:** ○ **English** ○ **Spanish** ○ **Other:**_____
Are you hearing impaired? Y N **Do you require an interpreter? Y N**	**Are you a Veteran? Y N**
Employer:	**Occupation:** ○ **Part Time** ○ **Full Time**
Email:	**Preferred Pharmacy:**

Signature of Patient or Legal Representative confirming above information is correct:

Name: _____ **Date:** _____