



Today's Date

**Patient Information**

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

First Name Used \_\_\_\_\_

Middle Name \_\_\_\_\_

Former Last Name \_\_\_\_\_

Legal Sex \_\_\_\_\_

Gender Identity  Male  Female  
 Transgender FTM  
 Transgender MTF  
 Gender non-conforming  
 Choose not to disclose  
 Other, Please specify: \_\_\_\_\_

Assigned Sex at Birth  Male  Female  
 Choose not to disclose  
 Unknown

Preferred Pronouns  he/him  she/her  
 they/them

DOB \_\_\_\_\_

Address \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Home phone \_\_\_\_\_

Mobile phone \_\_\_\_\_

Work phone \_\_\_\_\_

Contact preference HOME MOBILE WORK

May we text you? YES NO

Email (required) \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_

Preferred Lab \_\_\_\_\_

Preferred Radiology \_\_\_\_\_

Marital Status M \_\_\_\_\_

Homebound YES NO

Language \_\_\_\_\_

Race \_\_\_\_\_

Ethnicity \_\_\_\_\_

**Guardian**

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle name \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home phone \_\_\_\_\_

Mobile phone \_\_\_\_\_

**Next of Kin**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

**Employment**

Employer name \_\_\_\_\_

Employer phone \_\_\_\_\_

How did you hear about us?  
 Referred by Friend or Relative: \_\_\_\_\_  
 Referred by Another Doctor: \_\_\_\_\_  
 Privia Provider Online Directory  
 Insurance company  
 Advertisement  
 Online Search  
 Other, Please specify: \_\_\_\_\_



**Primary Insurance Information**

Insurance Plan Name \_\_\_\_\_  
ID/Certification No. \_\_\_\_\_  
Policy/Group No. \_\_\_\_\_

**Secondary Insurance Information**

Insurance Plan Name \_\_\_\_\_  
ID/Certification No. \_\_\_\_\_  
Policy/Group No. \_\_\_\_\_

**Primary Policy Holder (if other than patient)**

Patient's Relationship to policy holder: \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_  
Middle Name \_\_\_\_\_  
Address \_\_\_\_\_  
Address (ctd) \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Policy Holder Sex \_\_\_\_\_  
Employer Name \_\_\_\_\_

**Secondary Policy Holder (if other than patient)**

Patient's Relationship to policy holder: \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_  
Middle Name \_\_\_\_\_  
Address \_\_\_\_\_  
Address (ctd) \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Policy Holder Sex \_\_\_\_\_  
Employer Name \_\_\_\_\_

**Guarantor Information**

Last Name \_\_\_\_\_  
First Name \_\_\_\_\_  
Middle name \_\_\_\_\_  
DOB \_\_\_\_\_  
Address \_\_\_\_\_  
Address 2 \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip \_\_\_\_\_

**Optional Information**

Phone \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_