PATIENT DEMOGRAPHIC FORM
MACOMB MEDICAL CLINIC, P.C.
Please PRINT

TODAYS DATE_______/_______/_________

English Version:
Macomb Medical Clinic, P.C. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.
Spanish Version:
Macomb Medical Clinic, P.C. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Which Doctor / Provider do you have an appointment with?
☐ **Dr. Lieberman** ☐ **Dr. Rosenberg** ☐ **Dr. Kutinsky** ☐ **Dr. Ducato**
☐ **Brooke Tobia, PA-C.** ☐ **Dave Giancola, PA-C.**

Date of Birth: ____/____/_______ ☐ **Male** ☐ **Female** **Social Security #______/_______/__________**

Last Name: _____________________________________ First Name: ____________________________MI:________

Marital Status: (*Circle one*) Married Single Divorced Life Partner Separated Widowed Other

Preferred Language: (*Circle one*) English Spanish Other _____________________

Ethnicity: (*Circle one*) Hispanic/Latino Non-Hispanic/Non-Latino

Race: (*Circle one*) American Indian/Alaskan Native Asian American Black/African American
Middle Eastern American Multiracial (*2 or more races*) Pacific Islander/Native Hawaiian White American

Address: ____
Number / Street Apt# City State Zip Code

Cell (______) _______-__________ Home (______) _______-__________ Work (_____) _______-_________
****Please Circle the Preferred Phone Number that you would like us to use first when contacting you****

E-Mail Address: ____

Emergency Contact: ______________________________/_____________________(______)________-____________
Name Relationship Phone #

Emergency Contact: ______________________________/_____________________(______)________-____________
Name Relationship Phone #

Responsible Party if Patient is a Minor: ____________________________________Relationship _________________

Pharmacy Name: ____ Pharmacy # (________) ________-____________

Location and Crossroads____ Zip Code: ____________________

MAIL ORDER Pharmacy: ____

I authorize Macomb Medical Clinic, P.C., and those parties acting on behalf of Macomb Medical Clinic, P.C., to contact me about appointments, reminders for health services & test results via: (*Please Circle One*)

Home Phone Cell Phone Email Patient Portal All are acceptable

Is it ok to leave medical information on your answering machine or voice mail? (*Please Circle*) YES NO