CenterWell ACE

Patient Demographic Form

Patient Name: ______________________________ **DOB:** __________

Last First MI

Address: ______________________________

Street City State Zip

Residence Type: ☐ Private Home ☐ Independent Living ☐ Skilled Nursing Home ☐ Assisted Living ☐ Nursing Home ☐ Homeless Shelter ☐ Retirement Community ☐ Residential Home

Cell Phone: __________ **Home:** __________ **Work:** __________

Email: ______________________________

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Single ☐ Legally Separated

Emergency Contact Name: ______________________ **Phone #:** __________

Relationship: ______________________________

Gender Identity: What sex were you assigned at birth, on your original birth certificate? ☐ Male ☐ Female

Is there anything about your identity that you want your provider to know? ☐ Yes ☐ No

____

Primary Language: ☐ English ☐ Spanish ☐ Creole ☐ Other (Please Specify) __________

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Decline to Specify ☐ American Indian or Alaska Native ☐ Other (Please Specify) __________

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Decline to Specify

ADVANCE DIRECTIVES:

Do you have an Advance Directive? ☐ Yes ☐ No

(Written, legal instructions about your healthcare wishes and/or appointing someone to make medical decisions for you when you are no longer able to make them for yourself, such as a living will or durable healthcare power of attorney)

Do you have a Personal Representative? ☐ Yes ☐ No

(A person legally authorized to make healthcare related decisions on your behalf, such as a guara power of attorney, or designated healthcare advocate/surrogate/proxy)

If YES, Personal Representative's Name: ______________________________

PATIENT PORTAL:

Would you like to be web-enabled? This will provide access to our patient portal where you can view your appointments and medical information, send messages to your primary care office, request refills and more.

☐ Yes, I would like to be web-enabled ☐ No, I do not wish to be web-enabled at this time

If YES, please provide your email address: ______________________________

PHARMACY:

Preferred Retail Pharmacy	Mail Order Pharmacy
Name:	Name:
Address:	Address:
City, St, Zip:	City, St, Zip:
Phone:	Phone:
Fax:	Fax:

____
Signature of Patient or Patient's Legally Authorized Representative* **Date**

____
Printed Name of Legally Authorized Representative (if applicable) **Date**

*If representative, describe your authority to act for this individual and provide any corresponding documentation (guardian, power of attorney, healthcare surrogate, etc.): ______________

OFFICE USE ONLY

- ☐ Address validated; county added
- ☐ Rendering Provider added
- ☐ Signature date entered
- ☐ Default Facility is correct
- ☐ Web enabled if patient consented
- ☐ Structured data updated in Additional Info
- ☐ Default Lab documented
- ☐ If the emergency contact is HIPAA, the HIPAA box is checked
- ☐ All persons listed on HIPAA form added as contacts