Allen Park Family Physicians
Patient Demographic Form

Patient's Last Name:	First Name:		Middle Initial:
Date of Birth:	Age:	Gender: M F	Marital Status: S M D Sep W
Home Address:	City:		Zip:
Last 4 Digits of Social Security #:	Main Phone #:	Alternate #:	
Email:			
Employer Name:	Business Phone #:		
Emergency Contact:	Relationship:	Phone #:	
Guarantor (Insurance Card Holder) / Responsible Party (if different than above)			
Insured's Last Name:	First Name:		Middle Initial:
Relationship to Patient:	Date of Birth:		Gender: M F
Home Address:	City:		Zip:
Insured's Employer Name:	Business Phone #:		
Secondary Insurance Guarantor (Insurance Card Holder) / Responsible Party (if different than above)			
Insured's Last Name:	First Name:		Middle Initial:
Relationship to Patient:	Date of Birth:		Gender: M F
Home Address:	City:		Zip:
Insured's Employer Name:	Business Phone #:		

To help us best meet each patient's unique needs, it is useful for us to know your ancestry or ethnic background. Completion of the bottom portion of this form is voluntary.

1. Are you of Hispanic or Latino origin? ☐ Yes ☐No ☐Decline ☐Do not know

2. Are you of Arab or Chaldean origin? ☐ Yes ☐No ☐Decline ☐Do not know

3. Which of the following best describes your race? If necessary, you may select up to two.

   ☐ Asian ☐ Black ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander

   ☐ White ☐ Decline ☐ Do not know ☐ Other _____

4. Please provide one or two nationalities or ethnic groups that best describe your ancestry. (Examples: Italian, Korean, African American, Lebanese, etc.)

   1._____ 2._____

5. How would you rate your ability to speak English?

   ☐ Very well ☐ Well ☐ Not well ☐ Not at all ☐ Decline ☐ Do not know

6. What language do you feel most comfortable using when discussing your health care?

   ☐ Sign Language ☐ Arabic ☐ English ☐ Spanish ☐ Other:_____

Thank you. Please return this form to a front desk staff member.