Primary Care of the Treasure Coast, Inc.

Annual Demographic Update

please complete each of these items then sign below

«PatientAcccountNumer» / «ProviderName»

1) Patient Name: «FirstName» «LastName» Date of Birth: _____

2) If you would like to use our patient portal, please provide your **email. If not leave blank**: _____

3) Mailing Address: _____ _____
City, State, Zip

4) Street or Alternate (Northern) address: _____

5) Home: _____ Cell: _____

6) Employer Name: _____Number: _____ Retired ☐

7) Please circle one of the following: Single / Married / Divorced / Widowed

8) Spouse/Significant other: _____ Date of birth: _____ Phone: _____

9) I have a/an: Organ Donor Card ( ) Do Not Resuscitate Order ( ) Designated Healthcare Surrogate ( ) Power of Attorney ( ) Living Will ( )
I do not have any of these ( ). **Please provide a copy for your file.**

10) If applicable, please list any individual that takes care of you (helps in your day-to-day care):

Name: _____ Phone: _____

11) Who **outside your home** should we contact in case of emergency?

Name: _____ Relation: _____ Phone: _____

12) To whom may we release your medical information? All Family members ___ Spouse Only ___ Other____
Please list any individuals outside family: _____

13) Please list the name and general location of the pharmacy you would like for us to set as your main pharmacy.
We will use this pharmacy for each local prescription unless you tell us a different one.

Name: _____ Location: _____

******If you have not presented your insurance cards to us in the last 12 months,**
Please provide the receptionist with your most recent card(s) so we may update your file.****

Patient/Responsible party's Signature:

X_____ ***Date:*** _____