DEMOGRAPHICS – Salem Surgical Associates: This form updated yearly. _____Today's Date

**NAME:** _____ **Date of Birth:** _____

**Social Security Number**:_____ Which doctor are you seeing here? _____

Marital Status (Circle One): Single Married Separated Divorced Widowed Gender: M F Trans

Address:_____

City_____State_____ Zip_____

Home Phone: _____ Cell Phone:_____ Text Messages Ok? _____

**Employer**:_____Position Held: _____

Work Phone:_____ Circle One: FULL-TIME PART-TIME RETIRED DISABLED

E-Mail:_____ (To participate in our Patient Portal, this is required.)

**Primary Care Physician:** _____Phone:_____
Location/Practice Name:_____

**Pharmacy Name**:_____Phone:_____
Pharmacy Address/Location:_____

**Emergency Contact**: _____ Relationship:_____
Addresss: _____Phone: _____
**Please note, your emergency contact CANNOT obtain medical or personal information about you. If you would like to release such information, please ask for another form.**

**How Did You Hear About Us?** Physician _____ If Yes, Which One?_____
Website_____ Newspaper_____ TV_____ Friend_____ Other (Please specify):_____

**Do You Have One Of The Following?** _____ Surrogate Decision Maker _____ Living Will
_____ Do Not Resuscitate (DNR) _____ Power of Attorney (POA) _____ None of the Above

**Primary Insurance Company:** _____ Subscriber Name: _____

**Secondary Insurance:**_____Subscriber Name:_____

**IF PATIENT IS UNDER 18 YEARS OF AGE, THIS SECTION MUST BE COMPLETED**:
**Financially Responsible Party:** _____ DOB:_____
SSN:_____ Relationship to Patient:_____
Employer:_____Employer Phone:_____