Robert David Tufft MD

Patient Demographic Form

Patient Full Legal Name:_____ DOB:_____
Age: _____

Address/City/State/Zip

_____

Patient SS #:_____-_____-_____ Marital Status: S M D W Gender: M F
Race:_____

Home Phone#:_____ Cell Phone#:_____
Work Phone#:_____ Preferred Mode of Communication_____

Email Address #1_____ Email Address #2_____

Employed : Full-Time Part-time / Student Full-Time Part-time / Retired / Disabled / Not Employed.

Name of Employer or School: _____
Phone#:_____

Spouse Name:_____ Spouse DOB*:_____ (*We MUST have for insurance filing)

Spouse Employer:_____
Work Phone #:_____

Emergency Contact

Name (other than spouse)
_____Relationship:_____

Emergency Contact Phone#: Home _____ Cell _____
Work _____

If you become unable to handle your finances, who will be responsible:

_____

Please answer the following: Do you have a Living Will? Yes No

Do you have a Power of Attorney for Healthcare? Yes No

Who referred you to our office? _____

Phone _____

Who is your primary care physician? _____

Phone _____

Please list the full name of other physician(s) that you are current seeing:

1.)_____

2.)_____ 3.)_____

4.)_____