

WSU Sinai Grace Hospital

Infectious Diseases Clinic

Patient Information

Demographics:

Last Name: _____

First Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: (____) _____

Cell Phone: (____) _____

Cell Phone Provider: _____

May we have your permission to leave a message on your answering service or with a member of your household?

☐ Yes ☐ No

May we contact you by email if necessary?

☐ Yes ☐ No

If yes, email Address

May we Inbox you on facebook and/or Instagram if necessary?

☐ Yes ☐ No

If yes, contact information

Do you receive Case Management, Food Bank, or go to support groups

☐ Yes ☐ No

If yes, please list the names of the agencies

In Case of Emergency who should we call?

Name: _____

Relation to you: _____

Phone#: _____

Is Contact Aware of your Status:

☐ Yes ☐ No

If No, can status be revealed to emergency contact ONLY if necessary?

☐ Yes ☐ No

Name of Primary Care Physician: _____

Address: _____

Telephone Number: _____

Referred By: _____

Demographics:

Date of Birth: _____

SSN: _____

Sex:

☐ Male

☐ Female

☐ Transgender

Marital Status:

☐ Single

☐ Married

☐ Divorced

☐ Widowed

Race:

☐ Black

☐ White

☐ Asian

☐ Native Hawaiian

☐ Multiracial, _____

☐ Other, _____

Ethnicity:

☐ African

☐ African American

☐ American

☐ Asian/Indian

☐ European

☐ Hispanic/Latino

☐ Islander

☐ Middle Eastern

Other, _____

Employment Information:

Employed: ☐ Yes ☐ No

Employer Name: _____

Occupation: _____

☐ Full-time ☐ Part-time

Medical Insurance Name:

Medical Insurance ID Number:

Insured by: ☐ Self ☐ Other

If Other, Name on Insurance Card:

Relationship: _____

*I understand that I am financially responsible
for all charges not paid by my insurance
company.*

Patient

Signature: _____ Date: _____