UNC PHYSICIANS NETWORK
UNC HEALTH CARE

PATIENT INFORMATION

Full Name:	Address:
Birth Date:	City:
Age:	State: Zip:
Sex: ❑ Male ❑ Female	Primary Phone:
SSN#:	Work Phone:
Employment Status:	Mobile Phone:
Employer:	Secondary Phone:
Retirement Date *(if applicable)*:	Email:
Marital Status: ***Please Check One*** ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Domestic Partner	Race: ***Please Check One*** ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Other Pacific Islander ❑ Unknown/Other Race ❑ White or Caucasian
Ethnicity: ***Please Check One*** ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Unknown	Emergency Contact: Emergency Number: Relationship of Emergency Contact:
Preferred Language:	
If Patient is a MINOR: *Please Complete this Section*	
Parent 1 Name:	Parent 2 Name:
Parent 1 Birthdate:	Parent 2 Birthdate:
Parent 1 Phone:	Parent 2 Phone:
Is Parent 1 the Guarantor? Y N	Is Parent 2 the Guarantor? Y N

INSURANCE INFORMATION

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Member Number/ID for Patient:	Member Number/ID for Patient:
Group Number:	Group Number:
Group Name:	Group Name:
Subscriber Name *(name on card)*:	Subscriber Name *(name on card)*:
Subscriber Birthdate:	Subscriber Birthdate:
Relationship to Patient:	Relationship to Patient: