OSS Health

Downtime Demograhics

Today's Date _____

Treating Provider _____

Legal Name

First: _____ Last: _____ MI ____ Jr, Sr, II, III

Address

Street_____City_____State_____Zip_____

Phone

Home _____Mobile_____

Email _____

Date of Birth_____

Sex (Circle) Male Female Other

Sexual Orientation (Circle)

Straight/Heterosexual Lesbian/Gay/Homosexual Bisexual Queer Pansexual

Asexual Declined to Specify Something else, please describe

Gender Identity (Circle)

Male Female Transgender Male Transgender Female

Neither Exclusively Male or Female Not Sure/Questioning Declined to Specify

Additional gender category, please describe

Race (Circle)

White Black/African American American Indian/Alaska Native Asian

Native Hawaiian/Other Pacific Islander All Other Races Declined to Specify

Language_____

Pharmacy

Name_____

Street_____City_____State_____Zip_____

Family Doctor _____

Social Security # _____

Do you have an Advanced Directive/Living Well (Circle) Yes No

If yes,

Custodian Name_____ Relationship _____

OSS Health

Downtime Demograhics

Marital (Circle)

Married Domestic Partner Divorced Widowed Single

Commercial Insurance (Primary)

Name of Insurance _____

Group # _____ Member/Policy ID # _____

RX Bin# _____ RX Group # _____

Name of Insured_____ Relationship to Insured (if not patient) _____

Insured's Date of Birth _____ Insured's Employer _____

Commercial Insurance (Secondary)

Name of Insurance _____

Group # _____ Member/Policy ID # _____

RX Bin# _____ RX Group # _____

Name of Insured_____ Relationship to Insured (if not patient) _____

Insured's Date of Birth _____ Insured's Employer _____

Commercial Insurance (Tertiary/Third)

Name of Insurance _____

Group # _____ Member/Policy ID # _____

RX Bin# _____ RX Group # _____

Name of Insured_____ Relationship to Insured (if not patient) _____

Insured's Date of Birth _____ Insured's Employer _____

Work Comp Insurance

Name of Insurance _____

Claim # _____ Date of Injury _____

Injured Body Part _____ Employer _____

Employer Address _____
Street Address City State Zip

Auto Insurance

Name of Insurance _____

Insurance Address _____
Street Address City State Zip

Date of Injury _____ Injured Body Part _____

Claim # _____