Main Line Health®
Integrative and Functional Medicine Services

Main Line Health Center in Concordville
1020 Baltimore Pike | Suite 100
Glen Mills, PA 19342

TEL 484.227.7858
FAX 484.227.7877
mainlinehealth.org/integrativemedicine

Patient Demographic Information	
Patient Name (legal):	Date of Birth:
Preferred Name:	Gender at Birth: ☐ Male ☐ Female
Address:	Current Gender Identity:
Address:	Home Phone:
City: State: Zip:	Work Phone:
Marital Status: Single Married Widowed Separated Divorced Other	Cell Phone: Email:
Preferred Language:	Preferred Contact: ☐ Home ☐ Work ☐ Cell ☐ Email ☐ MyChart
Ethnicity: ☐ Not Hispanic, Latino/a or Spanish origin ☐ Hispanic, Latino/a or Spanish origin ☐ Unknown ☐ Decline to Answer	Race: *(Response is not mandatory. Data is used for statistical reporting.)* Please choose all that apply. ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American/Alaska Native ☐ Unknown ☐ Other ☐ Decline to Answer
Primary Care Provider:	Referring Provider:
Other Treating Providers (Name/Specialty):	
Are you visually impaired? ☐ Yes ☐ No Are you hearing impaired? ☐ Yes ☐ No Do you need an interpreter? ☐ Yes ☐ No	

Emergency Contact Information	
Name:	Relationship to Patient:
Address:	Home Phone: Work Phone:
City, State Zip	Cell Phone:

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Guarantor Information *Please complete if guarantor is other than self. The guarantor is the person financially responsible for this patient's bill.*	
Name:	Relationship to Patient:
Address:	Guarantor Date of Birth:
Address:	Home Phone:
City:	Work Phone:
State: Zip:	Cell Phone:

Insurance Information **A separate form is required for Worker's Compensation, Automobile Liability, or Legal services.*	
Primary Carrier:	Subscriber Name:
Insurance Address:	Relationship to Patient:
Telephone #:	Subscriber Date of Birth:
Effective Date:	Subscriber Employer:
ID/Cert#: Group Name/Plan:	

Secondary Carrier:	Subscriber Name:
Insurance Address:	Relationship to Patient:
Telephone #:	Subscriber Date of Birth:
Effective Date:	Subscriber Employer:
ID/Cert#: Group Name/Plan:	

Do you have a healthcare power of attorney? ☐ Yes ☐ No		Do you have a living will? ☐ Yes ☐ No	
How did you hear of our practice?			
*Is this visit a result of an accident (Auto/Worker's Comp/Personal Injury)? ☐ Yes ☐ No			
Pharmacy Name:	City:		Telephone#: