Demographic Information Form

Patient Name: _____
Date of Birth: _____ **Age:** _____
Home Address: _____

Gender Identity:
( ) Male ( ) Female ( ) Nonbinary ( ) Prefer to self-describe: _____

Sex Assigned at Birth:
( ) Male ( ) Female ( ) Intersex ( ) Prefer not to say

Pronouns:
( ) He/Him ( ) She/Her ( ) They/Them ( ) Other: _____

Race/Ethnicity: _____

Height: _____
Weight: _____

Hair Color: _____
Eye Color: _____

Handedness: _____

Current School or Employer: _____
Current or Highest Grade Level: _____

Best Contact Phone Number: _____
Best Contact Email: _____

Preferred Method of Contact:
( ) Phone ( ) Email ( ) Text ( ) Other: _____

Emergency Contact Name & Relationship: _____
Emergency Contact Phone Number: _____

Referral Information

Referred by (Name): _____
Referred by (Organization): _____

Parent/Guardian Information ***(For patients under 18)***

Parent/Guardian 1 Name: _____
Phone Number(s): _____
Email Address: _____

Parent/Guardian 2 Name: _____
Phone Number(s): _____
Email Address: _____

Parents' Marital Status: _____

If separated or divorced, do both parents consent to treatment?

( ) Yes ( ) No

According to the custody agreement, does one parent have sole medical decision-making authority?

( ) Yes ( ) No If yes, which parent? _____

Please provide MPG with copies of custody agreements or any legal documents relevant to medical decision-making authority.