Dr. Kent A. Logan, MD
Neurology Specialties Practice

Patient Demographics

Patient Name: _____ **Date of Birth:** _____

Legal Sex: Male Female **Marital Status:** _____

SSN: _____ **Preferred Name:** _____

Address: _____

Mailing Address: _____

Home phone: _____ **Mobile phone:** _____

E-mail Address: _____

Employer: _____ **Occupation:** _____

Emergency Contact (name, relationship to you & phone number):

_____

Preferred Language: English Spanish Other (please specify): _____ Decline/Prefer not to Answer

Race: American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Other Pacific Islander White Decline/Prefer not to Answer

Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline/Prefer not to Answer

Primary Insurance

Insurance: _____ Insurance ID number: _____

Name of Subscriber: _____ Subscriber DOB: _____

Secondary Insurance (if applicable):

Insurance: _____ Insurance ID number: _____

Name of Subscriber: _____ Subscriber DOB: _____

Tertiary Insurance (if applicable):

Insurance: _____ Insurance ID number: _____

Name of Subscriber: _____ Subscriber DOB: _____

Reason for Visit today:

_____

_____

_____

Referring Physician:

Name: _____ Phone Number: _____

Address: _____

Primary Care Physician:

Name: _____ Phone Number: _____

Address: _____

Allergies:

_____

_____

Current Medications:

_____

_____

_____

Preferred Pharmacy:

Pharmacy Name: _____ Phone number: _____

Pharmacy Address: _____