The Charis Center for Eating Disorders
Indiana University Health

Chart Label

PATIENT DEMOGRAPHIC INFORMATION

Legal Name _____ Date of Birth _____
Preferred Name _____ SSN _____ - _____ - _____
Address _____ City _____ State _____ Zip _____
Preferred Language: ____ English ____ Spanish ____ ASL ____ Other _____Marital Status _____

Sex on Legal ID (circle): Male / Female / Non-Binary / Other Preferred Pronouns:_____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ Hawaiian or Pacific Islander
□ White □ Unknown □ Declined

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Declined □ Unknown

Primary Phone _____ Alt. phone _____ Wk phone_____
Email Address _____ Preferred Contact Method? _____
Primary Care Doctor _____ Referring Doctor _____

Employment Status (Circle One) Full-time Part-time Disabled Retired Not Employed Self Employed On Active Duty
Employer Name: _____ Emp. Phone _____
Retirement Date (if applicable) _____

PATIENT PREFERRED PHARMACY INFORMATION

Pharmacy Name _____ City _____ Cross Section _____

GUARANTOR/ POLICY HOLDER INFORMATION

Patient Relationship to Guarantor _____ Date of Birth: _____ Gender: _____
Last Name _____ First Name _____ SSN _____
Address _____ City _____ State _____ Zip _____
Phone: _____ Alt. phone: _____ Email: _____
Employer Name: _____ Emp. Phone _____
Employer Address: _____ City _____ State _____ Zip _____

EMERGENCY CONTACT / NEXT OF KIN

Last Name _____ First Name _____
Relationship to NOK _____Date of Birth _____Phone: _____

PRIMARY INSURANCE INFORMATION

Name of Insurance: _____
Policy Holders Name _____ Date of Birth _____
Member ID# _____ Group# _____
Employer Name: _____

SECONDARY INSURANCE INFORMATION

Name of Insurance: _____
Policy Holders Name _____ Date of Birth _____
Member ID# _____ Group# _____
Employer Name: _____

Today's Date: _____