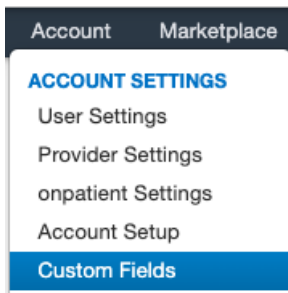


Using Custom Demographics to Record Attorney Information

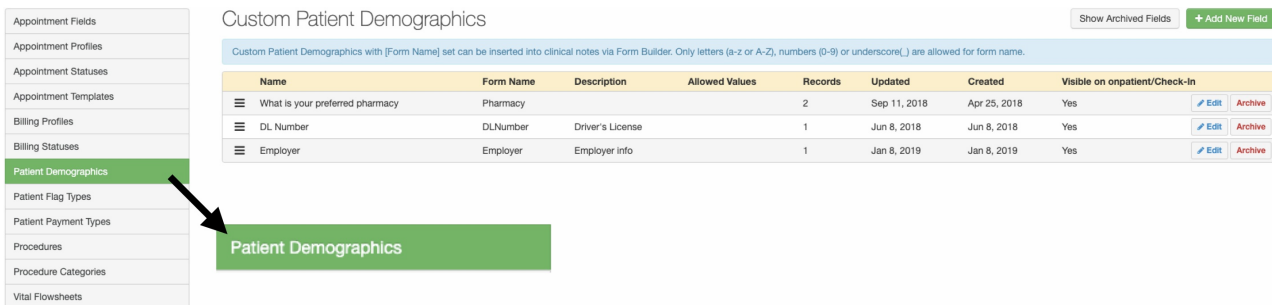
07/08/2024 7:58 pm EDT

You can use DrChrono's [custom demographics](#) feature to add fields to the patient's chart to document attorney information.

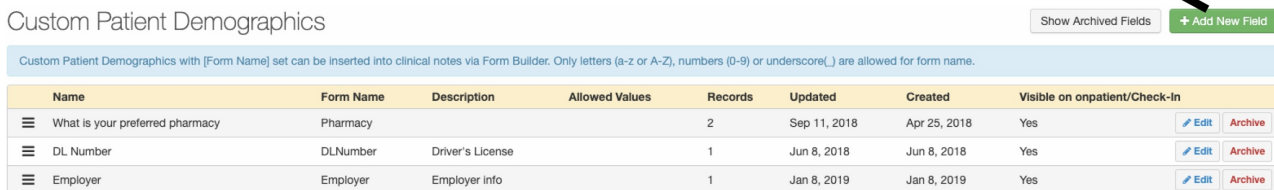
- Go to **Account > Custom Fields**.



- Select **Patient Demographics** from the menu on the left.



Click **+Add New Field** to create a field.



- Enter a name and description of the demographic you would like to create. Add any additional information or field settings and **Save**.
 - The description could serve as instructions or a description of the field.
- If you would like to pull information from this field into your clinical forms through the form builder, enter a **Form Name** in the field.
 - Select a **Field Type**.
- If you would like to display this during Check-In through OnPatient or the iPad App, check the **Show on OnPatient & DrChrono Check-In** checkbox.
- You can also make the field mandatory on OnPatient and Check-In by checking the **Required on OnPatient & DrChrono Check-In**.

Edit Custom Patient Demographics



Name	<input type="text" value="Attorney Name"/>
Description	<input type="text" value="Please provide your attorney's first and last name."/>
Form Name	<input type="text" value="AttorneyName"/>
Field Type	<input type="text" value="Text Field"/>
Show on onpatient & DrChrono Check-In	<input checked="" type="checkbox"/>
Required on onpatient & DrChrono Check-In	<input type="checkbox"/>

Repeat for other fields, for example, Attorney's Phone Number and Address.

Edit Custom Patient Demographics



Name	<input type="text" value="Attorney Address"/>
Description	<input type="text" value="Please enter your attorney's address."/>
Form Name	<input type="text" value="AttorneyAddress"/>
Field Type	<input type="text" value="Text Field"/>
Show on onpatient & DrChrono Check-In	<input checked="" type="checkbox"/>
Required on onpatient & DrChrono Check-In	<input type="checkbox"/>

Create Custom Patient Demographics



Name	<input type="text" value="Attorney Phone Number"/>
Description	<input type="text" value="Please enter your attorney's phone number."/>
Form Name	<input type="text"/>
Field Type	<input type="text" value="Text Field"/>
Show on onpatient & DrChrono Check-In	<input checked="" type="checkbox"/>
Required on onpatient & DrChrono Check-In	<input type="checkbox"/>

Once you have created the custom demographics fields, you can enter the information into the patient's chart.

Demographics
Appointments
Clinical Dashboard
Documents
Eligibility

Custom Demographics [Manage Custom Patient Demographics](#)

Attorney Name	<input type="text" value="Jessica Attorney"/>	Please provide attorney's first and last name.
Attorney Phone Number	<input type="text" value="650-555-5555"/>	Please enter your attorney's phone number
Attorney Address	<input type="text" value="123 Fake St. Anytown, ST 12345"/>	Please enter your attorney's address.
What is your preferred pharmacy	<input type="text" value="CVS"/>	
DL Number	<input type="text"/>	Driver's License

Patients can also enter this information when checking in with [OnPatient](#) or the [Check-In App](#).

More Information

Attorney Name

Please provide attorney's first and last name.

Attorney Address

Please enter your attorney's address.

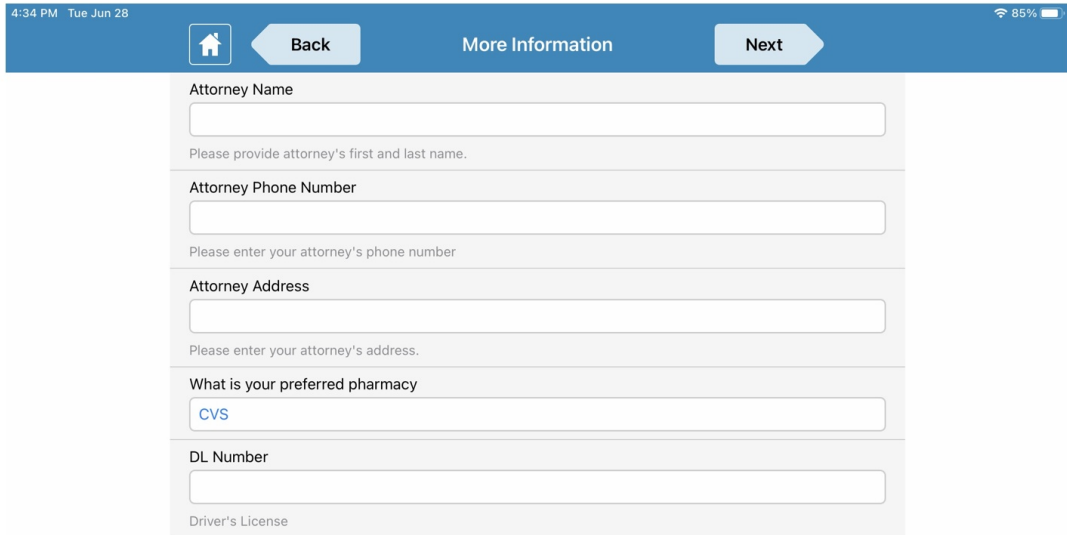
Attorney Phone Number

Please enter your attorney's phone number

What is your preferred pharmacy

DL Number

Driver's License



If needed, you can run a report on custom demographics using the [Advanced Report](#).

Patient Filter

<input type="checkbox"/> State	<input type="checkbox"/> Secondary Ins Plan ID	<input type="checkbox"/> Patient Allergy contains ALL of
<input type="checkbox"/> Home Phone	<input type="checkbox"/> Secondary Ins Plan Name contains ALL of	<input type="checkbox"/> Patient Allergy contains ANY of
<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Secondary Ins Plan Name contains ANY of	<input type="checkbox"/> Lab Test
<input type="checkbox"/> Cell Phone is blank	<input type="checkbox"/> Secondary Ins Plan Type	<input type="checkbox"/> Lab Test Result contains ALL of
<input type="checkbox"/> Office Phone	<input type="checkbox"/> Secondary Ins ID #	<input type="checkbox"/> Lab Test Result contains ANY of
<input type="checkbox"/> Email is blank	<input type="checkbox"/> First DOS After	<input type="checkbox"/> Lab Test Result >=
<input type="checkbox"/> No Credit Card on File	<input type="checkbox"/> First DOS Before	<input type="checkbox"/> Lab Test Result <=
<input type="checkbox"/> DOB After	<input type="checkbox"/> Last DOS After	<input checked="" type="checkbox"/> Attorney Name
<input type="checkbox"/> DOB Before	<input type="checkbox"/> Last DOS Before	<input checked="" type="checkbox"/> Attorney Phone Number
<input type="checkbox"/> Month of DOB	<input type="checkbox"/> Referring Dr. First Name	<input checked="" type="checkbox"/> Attorney Address
<input type="checkbox"/> Day of DOB	<input type="checkbox"/> Referring Dr. Last Name	<input type="checkbox"/> What is your preferred
<input type="checkbox"/> Sex		
<input type="checkbox"/> Ethnicity		
<input type="checkbox"/> Race		
<input type="checkbox"/> Preferred Communication		

Close

Custom Export

<input checked="" type="checkbox"/> Date of Birth	<input checked="" type="checkbox"/> Primary Ins Payer	<input type="checkbox"/> Ref Dr. Phone
<input checked="" type="checkbox"/> Primary Provider	<input checked="" type="checkbox"/> Primary Ins Payer ID	<input type="checkbox"/> Ref Dr. Fax
<input type="checkbox"/> Home Phone	<input checked="" type="checkbox"/> Primary Member ID	<input type="checkbox"/> Ref Source
<input checked="" type="checkbox"/> Cell Phone	<input checked="" type="checkbox"/> Primary Ins Plan Name	<input type="checkbox"/> Employer
<input type="checkbox"/> Office Phone	<input checked="" type="checkbox"/> Primary Ins Group #	<input type="checkbox"/> Employer Zip Code
<input checked="" type="checkbox"/> Email	<input type="checkbox"/> Secondary Ins Payer	<input type="checkbox"/> Employer Address
<input checked="" type="checkbox"/> Gender	<input type="checkbox"/> Secondary Ins Payer ID	<input type="checkbox"/> Employer City
<input type="checkbox"/> Race	<input type="checkbox"/> Secondary Member ID	<input type="checkbox"/> Employer State
<input type="checkbox"/> Ethnicity	<input type="checkbox"/> Secondary Ins Plan Name	<input type="checkbox"/> Expected Copay
<input type="checkbox"/> Marital Status	<input type="checkbox"/> Secondary Ins Group #	<input type="checkbox"/> Primary Care Physician
<input checked="" type="checkbox"/> Address	<input type="checkbox"/> Auto Insurance Payer	<input type="checkbox"/> Patient Flags
<input checked="" type="checkbox"/> City	<input type="checkbox"/> Auto Insurance Payer ID	<input checked="" type="checkbox"/> Attorney Name
<input checked="" type="checkbox"/> State	<input type="checkbox"/> Auto Insurance Case #	<input checked="" type="checkbox"/> Attorney Phone Number
<input checked="" type="checkbox"/> Zip Code	<input type="checkbox"/> Worker's Comp Payer	<input checked="" type="checkbox"/> Attorney Address
<input type="checkbox"/> Mailing Address	<input type="checkbox"/> Medical Case Payer ID	

Close Export