PATIENT DEMOGRAPHIC FORM

Patient Information

Name (Last, First, MI) | Date

Street Address | City | State | Zip

Home Phone ☐Preferred | Work Phone ☐Preferred | Cell Phone ☐Preferred

SSN | Date of Birth | Gender ☐Female ☐Male | Marital Status ☐ N/A (Child) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Religion (optional) | Ethnicity (optional) | e-mail address

Financially Responsible Party

Is patient responsible party/guarantor? ☐ Yes ☐ No

Name (Last, First, MI) | Relationship to patient

Street Address | City | State | Zip

Home Phone ☐Preferred | Work Phone ☐Preferred | Cell Phone ☐Preferred

Occupation | Employer | Date of Birth

Emergency Contact

Name | Relationship to Patient

Home Phone ☐Preferred | Work Phone ☐Preferred | Cell Phone ☐Preferred

Referral Info

Referring Physician's Name | Physician Phone/Fax (if known)

Physician Address | How did you hear about us? ☐ Physician ☐ Friend ☐Website ☐Newspaper ☐Radio/TV ☐ Other _____

PCP Info

Primary Care Physician's Name ☐ Same as Referring Physician above | Physician Number

Insurance Info

Primary Insurance Company | Policy # | Group #

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐Other _____ | Name of Subscriber (if other than patient)

Subscriber's Social Security # | Gender ☐ Male ☐ Female | Date of Birth | Employer of Subscriber | Work Phone

Secondary Insurance Company | Policy # | Group #

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐Child ☐ Other _____ | Name of Subscriber (if other than patient)

Subscriber's Social Security # | Gender ☐ Male ☐ Female | Date of Birth | Employer of Subscriber | Work Phone

I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certainclaims filed.

Patient /Guarantor Signature: _____ Date: _____/_____/_____

I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.
Patient Guarantor Signature: _____ Date: _____/_____/_____

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