Demographic Information Form

Name: _____ Date of Birth: _____
Last First Mi.

Gender: M or F Age: _____

Address: _____
Street

Marital Status: S M D W

_____
City State Zip

Social Security # _____

Email address: _____

Preferred language:_____ Race: _____ Ethnicity: _____

Telephone: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Employer: _____ Occupation: _____
Name

_____
Street City State Zip

Primary Care Doctor: _____ Primary Care Doctor's Phone #: _____

Referring Provider: _____ Pharmacy Phone #:_____ _____

Emergency Contact Person (s):

Name: _____ Phone: _____ Relationship to Patient: _____

Do we have your permission to discuss your case with certain specified relatives and/or friends of your choosing?

YES NO Name/Relationship: _____

Do we have your permission to leave messages on your answering machine at home or voicemail at work? YES NO

Insurance Information:

Insurance Plan: _____ ID #: _____

Policy Owner: _____ SS#: _____ D.O.B: _____

Employer of Policy Owner: _____ Phone: _____

Address: _____
Street City State Zip

Secondary Insurance: _____ ID#: _____

Policy Owner: _____ SS#: _____ D.O.B:_____

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates and payment terms of this office.
In the event I am entitled to health insurance or other benefits relating to my medical condition and they are available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. The office may release record of my treatment to my insurance company or other third parties responsible for payment of my medical charges.

Patient Signature: _____ **Date:** _____