Demographic Information Form

Name: ____ Date of Birth: ______________________
Last First Mi.

Gender: M or F Age: ____________

Address: ____ Marital Status: S M D W
Street

____ Social Security # ___________________
City State Zip

Preferred language:___________________ Race: ________________ Ethnicity: ______________________

Telephone: Primary: (Home/Cell/Work) _________________ Alternate: (Home/Cell/Work) _________________

Email address: _______________________________ Contact Preference: Email_____ Call_____ Other________

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

Employer: ____ Occupation: ______________________
Name

____
Street City State Zip

Primary Care Doctor: ________________________________ Primary Care Doctor's Phone:___________________

Referring Provider: ________________________________ Referring Provider's Phone:___________________

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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: ____

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:** ____________________