PATIENT DEMOGRAPHICS

PLEASE PRINT
Last Name:
First Name:
Middle Name:
Sex: Date of Birth:
Social Security No.:
Address:
Zip:
City: State:

Home Phone:
Work Phone:
Mobile Phone:
Email:
Marital Status:
Ethnic Group: Unknown/Hispanic or Latino/
NON-Hispanic or Latino
Race: American Indian/Alaska Native/Asian/
Black or African American/Native Hawaiian/Pacific Islander/White
Primary Language: English/Spanish/Other:

EMERGENCY CONTACT INFORMATION
Name:
Phone:

EMPLOYER INFORMATION
Name:
Phone:

GUARANTOR INFORMATION
Name:
Address:
DOB:

OTHER
Patient Referred By:

Patient's PCP:

Pharmacy Name and phone number:

PRIMARY INSURANCE INFORMATION
Insurance Plan Name:
Insurance Phone Number:
Policy ID/Certification No.:
Group No.:
Issue Date:
Exp Date:

Claims Address:

Policy Holder Name:
Address:

Date of Birth: __/__/__ Sex: M or F

SECONDARY INSURANCE INFORMATION
Insurance Plan Name:
Insurance Phone Number:
Policy ID/Certification No.:
Group No.:
Issue Date:
Exp Date:

Claims Address:

Policy Holder Name:
Address:

Date of Birth: __/__/__ Sex: M or F

ASSIGNMENT AND RELEASE:
**I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN.
**I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL NON-COVERED SERVICES.
**I AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS THIS CLAIM.

SIGNED:_____ DATE:_____