

Patient Demographic Information

(Please Print)

SS# _____ / _____ / _____ Patient's Name: _____

Permanent Address: _____ Apt# _____

City: _____ State _____ Zip _____

Local Address _____ Apt# _____

City: _____ State _____ Zip _____

Date of Birth: _____ Sex: (M / F) Marital Status: (S / M / W / D)

Home Phone: (_____) Age: _____ Email: _____

Cell Phone: (_____) Work Phone: (_____)

Primary Care Physician: _____ PCP Phone: (_____)

Who Referred You To Our Office?: _____

Patient Employer: _____

Primary Insurance

Secondary Insurance

Ins Co. Name: _____ Ins Co. Name: _____

Policy#: _____ Group# _____ Policy# _____ Group# _____

Relation to Patient: _____ Relation to Patient _____

Insured's Name: _____ Insured's Name: _____

Insured's Date of Birth _____ (M / F) Insured's Date of Birth: _____ (M / F)

Insured's Employer: _____ Insured's Employer: _____

Insured's SS#: _____ Insured's SS# _____

Who may receive information regarding your Protected Health Information (Check all that apply)

Spouse: _____ Name: _____

Children: _____ Name: _____

Name: _____

Name: _____

Name: _____

Parent/Guardian: _____ Name: _____

Sig Other/Friend: _____ Name: _____

May we leave messages regarding test results and appointments on your answering machine?

Yes _____ No _____

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this any time by giving written notification to this provider.

Date: _____ Signature _____

Circle One (Patient / Parent / Guardian)

WE BILL SECONDARY TO MEDICARE ONLY.