DEMOGRAPHIC AND INSURANCE FORM

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ City:_____ State:_____ Zip:_____

Gender: _____Male _____Female Employment: _____Employed _____Student _____Other

Phone:_____ Work Phone:_____ Cell Phone:_____

Preferred Phone (circle one): H W C Social Security #:_____ DOB:_____

Marital Status: _____Single _____Married _____Other Who Referred You?_____

PATIENT EMPLOYER INFORMATION:

Company:_____ Employer Phone#:_____

Address:_____ City:_____ State:_____ Zip:_____

RESPONSIBLE PARTY INFORMATION:

Last Name: _____ First Name:_____ Middle Initial:_____

Address: _____ City:_____ State:_____ Zip:_____

Gender: _____Male _____Female Employment: _____Employed _____Student _____Other

Phone: _____ Work Phone:_____ Cell Phone:_____

Preferred Phone (circle one): H W C Social Security #:_____ DOB:_____

Marital Status: _____Single _____Married _____Other Relationship to Pt._____

Company: _____ Employer Phone#:_____

Address: _____ City:_____ State:_____ Zip:_____

PATIENT'S PRIMARY CARE DOCTOR:

Doctor: _____ Phone: _____

Name of Practice:_____

Address: _____ City:_____ State:_____ Zip:_____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____Insurance ID Number of the Patient:_____

Insurance Address: _____ City:_____ State:_____ Zip:_____

Insurance Company Phone#: _____ Employer Plan: _____yes _____no

Group Name or #: _____ Policy Dates: From: ____/_____/_____ To:____/_____/_____

Insured Party Name:_____ Insured Party SS #:_____

Insured Party Address: _____ City:_____ State:_____ Zip:_____

Insured Party Phone #: _____ Insured Party DOB:_ ____/_____/_____

Emergency Contact Name: _____ Phone Number:_____

I hereby authorize payment directly to the medical provider and/pr Medical Benefits, if any, otherwise payable to me for his/ her services as described, realizing I am responsible to pay non-covered services. I also authorized the medical providers to release information acquired in the course of my treatment necessary to process insurance claims.

Signature:_____ **Date:**_____/_____/_____