PATIENT DEMOGRAPHICS & INSURANCE

PATIENT INFORMATION

PATIENT Last Name	First Name	MI	Sex (*check one*) ☐ **Male** ☐ **Female**

Street	Apt #	City	State	Zip

Home Phone # ☐ Primary Number	Work Phone # ☐ Primary Number	Cell Phone # ☐ Primary Number

Email Address	Marital Status (*check one*) ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Legally Separated** ☐ **Widowed**

Date of Birth (mm/dd/yyyy)	Social Security Number #	Employer Name

Primary Care Physician Name	Primary Care Phone #	Referring Physician Name	Referring Phone #

RESPONSIBLE PARTY

COMPLETE THIS SECTION ONLY IF THE PATIENT ABOVE IS A MINOR

RESPONSIBLE PARTY Last Name	First Name	MI	Relationship	Sex (*check one*) ☐ **Male** ☐ **Female**

Street	Apt #	City	State	Zip

Home Phone #	Work Phone #	Cell Phone #

Email Address	Marital Status (*check one*) ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Legally Separated** ☐ **Widowed**

Date of Birth (mm/dd/yyyy)	Social Security Number #	Employer Name

INSURANCE & SUBSCRIBER INFORMATION

We will file your claim for covered services with only the insurance companies our doctors are contracted with. **IF YOU HAVE AN HMO INSURANCE, YOU MUST HAVE A REFERRAL; OTHERWISE YOU WILL BE RESPONSIBLE FOR THE CHARGES.**

PRIMARY Insurance Company	Effective Date	**SECONDARY** Insurance Company	Effective Date
Claims Mailing Address (Street or Box)		Claims Mailing Address (Street or Box)	
City / State / Zip		City / State / Zip	
Policy ID Number	Group ID Number	Policy ID Number	Group ID Number
Subscriber Name (policy holder)	Date of Birth	Subscriber Name (policy holder)	Date of Birth
Subscriber Social Security #	Relationship to Patient	Subscriber Social Security #	Relationship to Patient
Subscriber Employer	Work Phone #	Subscriber Employer	Work Phone #
Subscriber Employer Address (Street or Box)		Subscriber Employer Address (Street or Box)	
City / State / Zip		City / State / Zip	