PATIENT DEMOGRAPHICS

Patient Name:____________________________

Date of Birth: ____________________________

Social Security Number: ____________________________

Mailing Address: ____________________________

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Home Phone: ____________________________

Cell Phone: ____________________________

Email Address: ____________________________

INSURANCE INFORMATION

Primary Insurance: ____________________________

Policy ID #:____________________________

Subscriber Name: ____________________________

Social Security #: ____________________________

Insurance Phone #:____________________________

Group #: ____________________________

Insured Date of Birth: ____________________________

Sex: ◯ Male ◯ Female

Secondary Insurance:____________________________

Policy ID #:____________________________

Subscriber Name: ____________________________

Social Security #: ____________________________

Insurance Phone #: ____________________________

Group #:____________________________

Insured Date of Birth:____________________________

Sex: ◯ Male ◯ Female

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR CHARGES INCURRED. I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN AND I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE.

____________________________ ____________________ ______________

Signature of Patient/Parent/Guardian Relationship to Patient Date