Stellar Medical Group

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www.stellarmgaz.com

PATIENT DEMOGRAPHIC FORM

Patient Information

Name (Last, First, MI)	Social Security #	Date Of Birth

Street Address	City	State	Zip

Home Phone ☐Preferred	Work Phone ☐Preferred	Cell Phone ☐Preferred

Gender	Marital Status
☐Female ☐Male ☐Other_____	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race(Optional) ☐ Decline	Ethnicity (Optional) ☐ Decline	E-mail address

Do you have a living will? ☐YES ☐ NO If yes, please provide a copy for our records.
Do you have a DNR? ☐ YES ☐ NO If yes, please provide a copy for our records.

Financially Responsible Party

Is patient responsible party/guarantor? ☐ Yes ☐ No

Name (Last, First, MI)	Relationship to patient

Street Address	City	State	Zip

Home Phone ☐Preferred	Work Phone ☐Preferred	Cell Phone ☐Preferred

Occupation	Employer	Date of Birth

Insurance Info

Primary Insurance Company	Policy #	Group #

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐Other _____	Name of Subscriber (if other than patient)

Gender ☐Female ☐Male ☐Other_____	Date of Birth	Employer of Subscriber	Work Phone

Secondary Insurance Company	Policy #	Group #

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐Child ☐ Other_____	Name of Subscriber (if other than patient)

Gender ☐Female ☐Male ☐Other_____	Date of Birth	Employer of Subscriber	Work Phone

I authorize Stellar Medical Group to perform, evaluate and treat, as they deem necessary. I further authorize my insurance company to pay Stellar Medical Group all medical benefits. I understand that ultimately, I am responsible for all charges not covered by my insurance as well as all deductibles; co-insurance and co pay amounts as determined by my insurance company. I understand that I will be responsible for all collection fees and all legal fees, if my account is placed with an outside collection agency. I hereby Stellar Medical Group to release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I certify that the information above is true and correct to the best of my knowledge. I will notify the practice Stellar Medical Group of any changes to this information.

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

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

Guarantor Signature (if other than patient): _____ **Date:** _____/_____/_____