# Stellar Medical Group

**|9139 W Thunderbird Rd, Suite 275,Peoria, AZ,85381|**
**|Ph.(623) 900-5181| Fax (623) 900-5290|**
**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:** _____/_____/_____