**Patient Demographic Form**

**CHAD A . CONATSER, M.D.**

**Patient # \_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **PATIENT INFORMATION** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Last Name | | First Name | | | | | MI |
| SS# | | | Sex | | Birthdate | | |
| Street Address | | | | City, State, Zip | | | |
| Home Phone | Other Phone | | | | | Work Phone (include extension) | |
| E-Mail Address 1 | E-Mail Address 2 | | | | | How did you hear about our practice? | |
| Employment Status  Full time Part time  Retired  Self  Student | Marital Status  Single  Married  Divorced  Widow | | | | | Student  Full time  Part time  None | |
| Employer Name | | | Employer Phone | | | | |
| Employer Address | | | City, State, Zip | | | | |
| **Emergency Contact Name** | | | Emergency Contact Relationship to Patient  Spouse  Parent  Child  Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Emergency Contact Phone** | Address | | | | | | |

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| **PRIMARY INSURANCE INFORMATION** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Insurance Company | | | Claims Address | | | | | | |
| Member # | | | | Group # or Name | | | | | |
| Subscriber is: Patient  Guarantor  Other  If other, please complete the rest of this section | | | | | | | | | |
| **Subscriber Last Name** | | | | | **Subscriber First Name** | | | | MI |
| **Subscriber SS#** | | | | | | | **Subscriber Birthdate** | | |
| Subscriber E-Mail Address | | | | | | | **Subscriber Phone #** | | |
| Street Address | | | | | | City, State, Zip | | | |
| Employment Status  Full time Part time  Retired  Self  Student | | Marital Status  Single  Married  Divorced  Widow | | | | | | Student  Full time  Part time  None | |
| Employer Name | Employer Address | | | | | | | City, State, Zip | |

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| **SECONDARY INSURANCE INFORMATION** |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Insurance Company | | | Claims Address | | | | | | |
| Member # | | | | Group # or Name | | | | | |
| Subscriber is: Patient  Guarantor  Other  If other, please complete the rest of this section | | | | | | | | | |
| Subscriber Last Name | | | | | Subscriber First Name | | | | MI |
| **Subscriber SS#** | | | | | | | **Subscriber Birthdate** | | |
| Subscriber E-Mail Address | | | | | | | Subscriber Phone # | | |
| Street Address | | | | | | City, State, Zip | | | |
| Employment Status  Full time Part time  Retired  Self  Student | | Marital Status  Single  Married  Divorced  Widow | | | | | | Student  Full time  Part time  None | |
| Employer Name | Employer Address | | | | | | | City, State, Zip | |

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| **SIGNATURE** |

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| **Payment Policy**: All services rendered are charged to the patient. Necessary claim forms will be completed to expedite insurance payments. The patient is responsible for all fees, regardless of insurance coverage. Payment is required at time of service, unless other arrangements have been made. **Patients with copay are required to pay on the date of service.** I understand that I am responsible for any amount not covered by insurance. **I agree to pay any balance due, in full, within 10 days of the statement**, unless other arrangements were made, in advance. If payment is not made in a timely manner and collection action becomes necessary, the signature below shall serve as authorization to release the information necessary to the collection agency selected by the provider(s) who have provided service to me.  **Insurance Authorization and Assignment:** I hereby authorize the release of any medical or other information (necessary to process a claim) on my insurance carrier. I also request payment of government benefits (if any apply) either to myself or the party who accepts assignment. Furthermore, I authorize payment of medical benefits directly the medical provider(s) who have treated me or rendered services or materials.  **Medicare Patients:** I authorize any holder of medical or other information about me to release to Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for this or related Medicare claim. I request that payment of authorized Medicare benefits be made either to me or to the party who accepts assignment.  **\*Authorization for Release of Information to Email Address (if one is provided above):** We collect email addresses for the purpose of notifying patients of business announcements. We may collect and use personal data for the additional purpose of sending advertisements pertaining to specific medical conditions. We do not disclose your personally identifiable information to any outside businesses or organizations, other than for the purposes mentioned in the paragraph above regarding insurance Claims.  **Treatment Consent:** I consent to treatment from Chad A. Conatser, M.D. | |
| Signature: | Date Signed: |