DEMOGRAPHICS FORM

Name:_____ **Date of birth:**_____ **Date completed:**_____

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Other, specify _____

Street Address: _____ **Phone:**_____ (Home/Cell)

City: _____**Additional Phone numbers:**_____

State/Zip:_____ _____

☐ Female ☐ Male ☐ Other, describe_____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered

List your children with ages: _____

_____

List current members of your household: _____

_____

Preferred language: _____ Place of birth (country): _____

Race: _____ Ethnic Group: _____

☐ Decline to answer, initials _____

Do you have any special needs in any of the following areas? ☐ Vision ☐ Hearing ☐ Reading ☐ Attention

☐ Mobility, describe _____

☐ Other, describe _____

Education: ☐ Grade Completed _____ ☐ GED ☐ Graduated High School ☐ Some College _____ years

☐ Bachelor's Degree ☐ Master's Degree ☐ Ph.D.

Occupation: _____

Employment: ☐ Full-time ☐ Part-time ☐ Retired ☐ At home / homemaker ☐ Looking ☐ Disabled

Employer: _____ Hazard exposure: ☐ No ☐ Yes, explain _____

☐ Student, school: _____

Have you served in Armed Forces? ☐ No ☐ Yes, what branch and dates: _____

List hobbies and leisure activities: _____

_____

Name:_____ **Date of birth:**_____ **Date completed:**_____

Primary Insurance:

Insurance Plan _____ ID # _____

Group # _____ ID suffix _____

Insurance Subscriber: ☐ Self ☐ Spouse ☐ Parent. If different than self:

Subscriber's Name:_____ Date of birth: _____ Subscriber's SSN: _____

Subscriber's Address: ☐ Same as above, or:

Street Address: _____ Phone:_____

City: _____ State/Zip:_____

Occupation: _____ Employer: _____

Secondary Insurance:

Insurance Plan _____ ID # _____

Group # _____ ID suffix _____

Insurance Subscriber: ☐ Self ☐ Spouse ☐ Parent. If different than self:

Subscriber's Name:_____ Date of birth: _____ Subscriber's SSN: _____

Subscriber's Address: ☐ Same as above, or:

Street Address: _____ Phone:_____

City: _____ State/Zip:_____

Occupation: _____ Employer: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize AVP Primary Care, PLLC and my insurance company to release any information required to process my claims.

Please sign and date below:

_____ _____

Signature of Patient / Legal Guardian Date