DEMOGRAPHIC AND INSURANCE FORM

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ City:_____ State:_____ Zip:_____

Gender: ____Male ____Female Employment: ____Employed ____Student ____Other

Phone:_____ Work Phone:_____ Cell Phone:_____

Preferred Phone (circle one): H W C Social Security #:_____ DOB:_____

Marital Status: ____Single ____Married ____Other Who Referred You?_____

PATIENT EMPLOYER INFORMATION:

Company:_____ Employer Phone#:_____

Address:_____ City:_____ State:_____ Zip:_____

RESPONSIBLE PARTY INFORMATION:

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ City:_____ State:_____ Zip:_____

Gender: ____Male ____Female Employment: ____Employed ____Student ____Other

Phone:_____ Work Phone:_____ Cell Phone:_____

Preferred Phone (circle one): H W C Social Security #:_____ DOB:_____

Marital Status: ____Single ____Married ____Other Relationship to Pt._____

Company:_____ Employer Phone#:_____

Address:_____ City:_____ State:_____ Zip:_____

PATIENT'S PRIMARY CARE DOCTOR:

Doctor:_____ Phone:_____

Name of Practice:_____

Address:_____ City:_____ State:_____ Zip:_____

PRIMARY INSURANCE INFORMATION:

Insurance Company:_____Insurance ID Number of the Patient:_____

Insurance Address:_____ City:_____ State:_____ Zip:_____

Insurance Company Phone#:_____ Employer Plan: ____yes ____no

Group Name or #:_____ Policy Dates: From:___/___/___ To:___/___/___

Insured Party Name:_____ Insured Party SS #:_____

Insured Party Address:_____ City:_____ State:_____ Zip:_____

Insured Party Phone #:_____ Insured Party DOB:___/___/___

Emergency Contact Name:_____ Phone Number:_____

I hereby authorize payment directly to the medical provider and/pr Medical Benefits, if any, otherwise payable to me for his/ her services as described, realizing I am responsible to pay non-covered services. I also authorized the medical providers to release information acquired in the course of my treatment necessary to process insurance claims.

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