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**DEMOGRAPHIC FORM** DATE: / /

# PATIENT NAME:

DOB AGE MALE FEMALE OTHER

ADDRESS:

PHONE: EMAIL:

May we leave you messages on your answering system regarding appointment reminders and/or services that may

interest you? YES NO

NAME OF EMPLOYER:

OCCUPATION:

MARTIAL STATUS: SINGLE MARRIED SEPERATED/DIVORCE

REFERRED BY:

PRIMARY CARE PHYSICIAN:

EMERGENCY CONTACT NAME: PHONE #:

Legal Authorized Representative (LAR) is a person authorized by law to act on behalf of an individual which includes, parent, guardian, or manager conservator.

DO YOU HAVE AN ASSIGNED LEGAL AUTHORIZED REPRESENTATIVE (LAR)? YES NO

NAME: PHONE

ADDRESS:

# INSURANCE NAME:

MEMBER ID: GROUP ID (IF APPLICABLE)

AUTHORIZATION NUMBER:

**COPY OF INSURANCE CARD NEEDED**