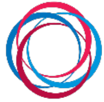

PATIENT DEMOGRAPHIC FORM

Patient Information

Name: ______________________________ Date of Birth: ________________

Address: ________________ City: ____________ State: ____________ Zip: ______

Home Phone: ______________ Cell Phone: ________ Email: ____________________

☐ Male ☐ Female ☐ Employed ☐ Retired ☐ Other ☐ Married ☐ Single ☐ Other

Companion/Relative Name: ____________________ Phone: ____________________

Primary Doctor: ____________________________ Phone: ____________________

Referring Physician: ________________________ Phone: ____________________

Would you like your results sent to your family doctor? ☐ Yes ☐ No

How did you hear about us? Referred By: Doctor: __________ (Name) Friend: ____________________ (Name)

Newspaper: ______________ (Name of Paper) Mailing: __________ (Type) Other: ____________________ (Yellow Pages, Internet, Signage, Outreach)

Insurance Information - Please provide Insurance Card(s) with this completed

Policy Holder's Name: ______________________ Policy Holder's Date of Birth: __________

Address: ________________ City: ____________ State: ____________ Zip: ______

Insurance Company: ________________________ Insured's ID#: ________________

Policy Group ID#: __________________________ Social Security#: ______________

Insurance Plan Name/Program: ________________ Policy Holders Relationship: __________ (self, spouse, child, other)

Do you have Medicare Coverage? ☐ Yes ☐ No

Policy Holder's Employer Name: ______________ Phone: ____________________

Secondary Insurance Information

Policy Holder's Name: ______________________ Policy Holder's Date of Birth: __________

Address: ______________ City: __________ State: ___________ Zip: ______

Insurance Company: ______________________ Insured's ID#: ______________

Policy Group ID#: ______________________ Social Security#: ______________

Insurance Plan Name/Program: ______________ Policy Holders Relationship: __________
(self, spouse, child, other)

Do you have Medicare Coverage? ☐ Yes ☐ No

Policy Holder's Employer Name: ______________ Phone: ______________

Financial Agreement

We participate in many different insurance plans. We will file your Insurance claims for the companies with whom we are contracted. You will be responsible for any co-payments or deductibles at the time services are rendered. For some insurance we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is our responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You will be responsible for co-payment, deductibles, out-of-network amounts or any portion your insurance company indicates is your responsibility. Payment for co-pays are expected at the time of service. If this fee is not covered by insurance it will be your responsibility. We allow your insurance company 45 days to pay your claim. If we do not receive payment in 45 days, you will be given a bill at that time. For our HMO/PPO patients, if we are contracted with your HMO/PPO, you will not receive a bill until we have heard from your Insurance company.

I have read and agree to the terms above:

____

Signature of Patient or Legal Representative Date

____

Signature of Insurance Policy Holder Date

____

Relationship to Patient Date