PATIENT DEMOGRAPHIC INFORMATION
(Please Print)

SS#: _____-____-_____ PATIENT NAME: _____
Last Name First Name M.I.

PERMANENT ADDRESS: _____APT.#_____

CITY: _____STATE_____ZIP_____

DATE OF BIRTH: _____/_____/_____ SEX: (M / F) MARITAL STATUS: (S / M / W / D)
Month Day Year

Phone # : (_____) _____-_____ Work Phone # : (_____) _____- _____
Other Phone # : (_____) _____-_____

PRIMARY CARE PHYSICIAN: _____PCP Phone: (_____) _____-_____
Last Name First Name

PATIENT EMPLOYER: _____

PRIMARY INSURANCE

Ins. Co. Name_____
Policy #: _____Group #: _____
Relation to Patient: _____
Insured's Name: _____
Insured's Date of Birth: _____ M / F
Insured's Employer: _____
Insured's SS# _____

SECONDARY INSURANCE

Ins. Co. Name_____
Policy #: _____ Group #: _____
Relation to Patient: _____
Insured's Name: _____
Insured's Date of Birth: _____ M / F
Insured's Employer: _____
Insured's SS# _____

Who may receive information regarding your Protected Health Information? (Check all that apply)

Spouse _____ Name: _____ Date of Birth: ____/____/_____
Children_____ Name: _____ Date of Birth: ____/____/_____
Name: _____ Date of Birth: ____/____/_____
Name: _____ Date of Birth: ____/____/_____
Name: _____ Date of Birth: ____/____/_____
Parent/Guardian ____ Name: _____ Date of Birth: ____/____/_____
Name: _____ Date of Birth: ____/____/_____
Significant Other/Friend: _____ Name: _____ Date of Birth: ____/____/_____
Name: _____ Date of Birth: ____/____/_____

May we leave messages regarding test results and appointments on your answering machine?
Yes _____ No _____

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

Date: _____ Signature: _____
Circle One (PATIENT / PARENT / GUARDIAN)

IF YOU HAVE TWO INSURANCE COMPANIES, PLEASE PRESENT BOTH CARDS SO THAT WE MAY FILE WITH YOUR SECONDARY CARRIER FOR ANY BENEFITS DUE YOU.