Demographic Form

Name:_____Today's Date:_____

Address:_____City:_____State:_____Zip:_____

Date of Birth:_____Social Security #:_____Age:_____

Home Phone:_____Work Phone:_____

Occupation:_____Employer:_____

Marital Status: Single_____ Married_____ Divorced_____ Widowed_____ Seperated_____

Emergency Contact:_____Relationship:_____

Home Phone:_____Work Phone:_____

Partner's Name:_____Age:_____Occupation:_____

Date of Birth:_____Contact Number:_____Employer:_____

Referring Physician's Name (if applicable)_____

Physician's Address:_____City: _____State:_____Zip:_____

Physician's Phone:_____Physician's Fax:_____

Primary Care Insurance Company:_____

Policy #:_____Group #:_____

Claims Address:_____Phone:_____

Patient's Relationship To Insured: Self_____ Spouse_____ Child_____ Other_____

Name of subscriber(if other than patient):_____

Subscriber's Social Security #:_____Gender:_____Date of Birth:_____

Secondary Insurance Company:_____

Claims Address:_____Phone:_____

Patient's Relationship To Insured: Self_____ Spouse_____ Child_____ Other_____

Name of subscriber(if other than patient):_____

Subscriber's Social Security #:_____Gender:_____Date of Birth:_____

First day of most recent menstrual period:_____
Is patient pregnant? Yes_____ Unknown_____

Total # of pregnancies including current & miscarriages?____

Known # of fetuses this pregnancy?____

Please read the following and sign below:

Assignment of Benefits and Release Information
I hereby authorize my insurance benefits to be paid directly to the undersigned physician. I understand that I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

Medicare Patients
I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine benefits for this or a related Medicare claim. I request that payment of authorized Medicare benefits be made either to me or to the party who accepts assignment.

Notice of Privacy Practices Acknowledgement
By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

Signature:_____Date:_____

PATIENT FINANCIAL LIABILITY STATEMENT

I understand that I am personally responsible for charges incurred for services rendered by any of the following apply:

- My health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at and I have not obtained such an authorization or referral or I receive services in excess of such authorization or referral.

  And/or

- My health plan determines that the services I receive at is not medically necessary.
- My health plan coverage has lapsed or expired at the time I receive services at

  And/or

- I have chosen not to use my health plan coverage.

I also understand that I am responsible for all co-payments and co-insurance sums under my health plan. My credit card will be charged for all the above reasons.

Print Patient Name:_____

Print Guarantor's Name if not Patient:_____

Signature of Financial Responsible Party:_____

Credit Card Type:_____Name on Card:_____

Card Number:_____3 Digit Security Code:_____

Expiration Date:_____Today's Date:_____

INFORMATION ABOUT YOUR APPOINTMENT

We are pleased that you have chosen for your medical care. We will make every effort to assist you in obtaining insurance per-authorization for your medical care. There are, however, many medical procedures that are not covered by insurance. You are ultimately responsible for all payment for your medical care.

You agree to accept financial responsibility for co-payments and co-insurance, deductibles and all other medical care you receive. Furthermore, you agree to accept responsibility for understanding your insurance plan's benefits and limitations, as well as the regulations regarding pre-authorizations and referrals. If medical care is rendered without the appropriate pre-requisites, or without insurance coverage, you agree to assume financial responsibility for those services that were denied.

Patient's Name:_____

Signature:_____**Date:**_____