

D e m o g r a p h i c s and Insurance

Patient Information

Last name: _____

Previous Last name *if applicable*: _____

First name: _____

Previous First Name *if applicable*: _____

SSN: _____

Date of birth: ____/____/____ **Sex:** ____M/____F **Marital Status:** Married / Single / Widowed / Divorced

Mailing Address: _____ **Apt / Lot:** _____

City: _____ **State:** _____ **Zip:** _____

Primary phone: (____) _____ - _____ **Secondary phone:** (____) _____ - _____

Email Address: _____

Pharmacy Name and cross street: _____ **PCP:** _____

Emergency Contact: **Name:** _____ **DOB** _____ **Relation:** _____
Phone: (____) _____ - _____

Who may receive information regarding your Protected Health Information?

Name: _	_ DOB	Phone: (____)_	-Relation: _	_
Name: _	_ DOB	Phone: (____)_	- Relation: _	_
Name: _	_ DOB	Phone: (____)_	- Relation: _	_
Name: _	_ DOB	Phone: (____)_	- Relation: _	_
Patient employer: _				_

Primary insurance company: _____ **PolicyID:** _____

Group no: _____

Policy holder/guarantor: _____ **Date of birth:** ____/____/____

Relation to patient: _____ **Policyholder/guarantor employer:** _____

Secondary insurance company: _____ **Policy:** _____

Group: _____

Policy holder/guarantor: _____ **Date of birth:** ____/____/____

Relation to patient: _____ **Policyholder/guarantor employer:** _____

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

I have received a copy of the Notice of Privacy Practices 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.

Signature: _____

Date: _____