

Patient Demographic Sheet

Patient Name: _____ Date of Birth _____
 Address _____ City _____
 State _____ Zip Code _____ HM Phone # _____ WK# _____
 Sex: M F Marital Status: M S D W Social Security # _____

HIPAA REQUIREMENTS

Release of Information:	Signature Source	Circle Y=yes or N-No
<input type="checkbox"/> A - Appropriate Release of Info on File	<input checked="" type="checkbox"/> B-Signed Signature Authoriz. Block 12 & 13	Pregnant Y N
<input type="checkbox"/> I - Informed Consent to Release Medical	<input type="checkbox"/> C-Signed HCFA-1500 Form on File	If Yes LMP _____
<input type="checkbox"/> M- Provider has Limited Release Data	<input type="checkbox"/> M-Signed Signature Authoriz. Block 13 Only	Home Bound Y N
<input type="checkbox"/> N- No. Provider is Not Allowed to Release	<input type="checkbox"/> P-Signature by Provider, Patient not Present	Hospice Y N
<input type="checkbox"/> O- On File at Payer	<input type="checkbox"/> S-Signed Signature Authoriz. Block 12 Only	
<input checked="" type="checkbox"/> Y- Yes, Provider has Signed Release		

Referring Physician _____ Phone _____
 Family Physician _____ Phone _____
 Reason for Appointment _____
 Employer _____ Employer Phone _____
 Emergency Contact _____ Emergency Phone Number _____
 Guarantor Responsible for Bill _____ Phone Number _____
 Spouse Name _____ Spouse Employer _____

INSURANCE INFORMATION - PRIMARY (Please Attach a Copy of the Front and Back of Patient Insurance Card (s).

Cardholder's Name _____ Date of Birth _____
 Insurance Co. Name _____ Address _____
 Id / Certificate Number _____ Group Number _____
 Insurance Co Tele. Number _____ Relationship to Patient _____

INSURANCE INFORMATION - SECONDARY (Please Attach a Copy of the Front and Back of Patient Insurance Card (s).

Cardholder's Name _____ Date of Birth _____
 Insurance Co. Name _____ Address _____
 Id / Certificate Number _____ Group Number _____
 Insurance Co Tele. Number _____

I, the undersigned, am aware that I am responsible for the payment of any co-pays and/or deductibles that may apply under my medical insurance contract. It is my responsibility to check with my insurance company to be sure that the physician is in my insurance network. I assume personal responsibility for any amount that insurance does not pay and deems payable by myself. I also agree to pay all fees if I have no insurance coverage. It is my responsibility to have a referral at the time of service. If I do not have a referral, I will pay all fees.

I, the undersigned, have received the Practice's notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

I authorize the release of any medical information necessary to process my claims, and payment of government benefits to the above mentioned office.

Patient or Authorized Signature: _____ Date _____