PATIENT DEMOGRAPHICS

Due to changes in Federal/State Regulations, we are requesting more personal and demographic information.

First Name: ________________________________ **MI:** _____

Last Name: ____

Address: ____

City: __________________________ **State:** _____ **Zip Code:** _____

Home Phone: ______________ **Mobile:** ____________ **Work:** _____

What is the best way that we can contact you?

☐ **Home Phone** ☐ **Mobile/Text** ☐ **Email/Portal** ☐ **Work**

Email: ____

Date of Birth ___/___/____ **Sex:** ☐ **Male** ☐ **Female**

Race:

☐ White ☐ Black/Africain American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaii/Other Pacific Islander ☐ If not list ______________

Marital Status:

☐ Annulled ☐ Divorced ☐ Legally Separated ☐ Married ☐ Widowed

☐ Domestic Partner ☐ Never Married ☐ Disabled

Student Status: ☐ Full Time ☐ Part Time ☐ Not a Student

Ethnicity:

☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to specific

Language: Primary:_______________ Secondary:_______________

Employment Status:

☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed ☐ Self Employed

☐ Active Military ☐ Unknown

Pharmacy Name & Location: _______________________________

Pharmacy Phone: _______________________________

Name of Insurance Company: _______________________________

Policy Holder's Name: _______________________________

Policy Holder's Date of Birth: ____/____/_____

Policy #: _______________________ **Group#:** _______________

Address: _______________________________

City: _______________ **State:** __________ **Zip Code:** __________

Name of person responsible for bill: _______________________________

Patient Authorization

I authorize the releases of any medical information necessary to process insurance claims and the release of information back to my Physician.

I request that payment of the authorized Medicare benefits be made better to me or on my behalf to this office for any services furnished by that physician to me. I authorize any holder or medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any required information. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signed: _______________________________ **Date:** ___/___/_____