**FAMILY MEDICINE OF MALTA**

PATIENT DEMOGRAPHICS

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the best way that we can contact you for reminders of appointments?

 Home Phone Mobile/Text Email/Portal Work

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_\_\_ Sex: Female Male

**Race:**

 White Black/African American American Indian/Alaska Native

 Asian Native Hawaii/Other Pacific Islander If not listed

**Sexual Orientation:**

Straight Lesbian Gay Bisexual Asexual Queer Pansexual Decline to Specify

**Gender Identity:**

Female Male Transgender Male Transgender Female Non-Binary Declined to specify

**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 DOB \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person responsible of the 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 the physician to me. I authorize any holder or medical information about me to release to the Centers for Medicare, Medicaid Services and its agents any required information. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_/\_\_\_\_/\_\_\_\_\_