



PATIENT DEMOGRAPHICS

Patient Information

Patient's First Name _____ Middle _____ Last _____

Nickname _____ Male _____ Female _____ Birth Date ____ / ____ / ____ Primary Physician _____

Parent 1 Name _____ Date of Birth _____

Parent 2 Name _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip Code _____

Are the home address and billing address the same? Yes No (Enter billing address below)

Billing Address _____ City _____ State _____ Zip Code _____

Email Address _____ Owner of Email _____

Primary Phone Number _____ Home _____ Mom Cell _____ Dad Cell _____ Other _____

2nd Phone Number _____ Home _____ Mom Cell _____ Dad Cell _____ Other _____

3rd Phone Number _____ Home _____ Mom Cell _____ Dad Cell _____ Other _____

4th Phone Number _____ Home _____ Mom Cell _____ Dad Cell _____ Other _____

Ethnicity: Hispanic/Latino _____ Not Hispanic/Latino _____ Prefer not to answer _____

Race: White _____ American Indian/Alaskan Native _____ Asian _____ Black/African American _____ Native HI/Pacific IS _____ Prefer not to answer _____

Preferred Language _____ Other Language _____

Do you need an interpreter? Yes _____ No _____ What Language? _____

Insurance Information

Primary Insurance Name _____ Copay _____

ID Number _____ Group Number _____

Subscriber's Name _____ Birth Date _____ Start Date _____

Employer _____

Secondary Insurance Name _____ Copay _____

ID Number _____ Group Number _____

Subscriber's Name _____ Birth Date _____ Start Date _____

Employer _____

Insurance Authorization and Assignment (Please read and Sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my visits to my insurance carrier. **I understand that I am responsible for my entire bill unless this form is complete.**

Parent/Guardian/Patient Signature _____ Date _____