PATIENT DEMOGRAPHIC FORM

*** Denotes required fields.**

If you are filling out this form on behalf of the patient, what is your name/relation to patient? _____

* Patient's Name (Last Name, First Name): _____ MI: _____

Parent 1's Name (if patient under 18): _____ Parent 1 Contact #: _____

Parent 2's Name (if patient under 18): _____ Parent 2 Contact #: _____

* Sex Assigned at Birth: ☐ Male ☐ Female ☐ Decline to specify Pronouns: _____

* Date of Birth (MM/DD/YYYY): _____

* Marital Status: Single / Married / Other (circle one)

* Race (check at least one)
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Decline to specify

* Ethnicity (check one)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to specify

Preferred Language: _____

Gender Identity: _____ Sexual Orientation: _____

Patient's Employer: _____ Title / Occupation: _____

* Is the patient the preferred point of contact? YES / NO

If **NO**: who is the preferred point of contact? _____ Relation to the patient: _____

Please provide the following information for the preferred point of contact.

* Physical Address _____

* City _____ State _____ Zip Code _____

Mailing Address (if different) _____

City _____ State _____ Zip Code _____

* Email Address: _____

* Phone number: _____ **Consent to Text:** ☐ Yes ☐ No

* Preferred Method of Communication (email/phone/mail): _____

* Emergency Contact Name: _____ Relationship to patient: _____

* Emergency Contact Phone Number: _____

* Preferred Pharmacy: _____ Address: _____

CONTINUES ON NEXT PAGE →

PATIENT DEMOGRAPHIC FORM

GUARANTOR INFORMATION

Please fill out the information regarding the person responsible for paying bills not covered by the patient's insurance. This may or may not be the policy holder of the insurance.

Please check this box if guarantor is the patient and sign below as guarantor: ☐

Guarantor Last Name	**First Name**	**Middle Initial**	**Suffix**	**Date of Birth**

Patient's Relationship to Guarantor: ☐ Child ☐ Other (Specify: _____)

Guarantor Phone Number	**Guarantor Email Address**

Guarantor Mailing Address	**City**	**State**	**ZIP**

INSURANCE INFORMATION

Please give the front desk your insurance card so we may have a copy on file. Please complete the insurance information below to ensure billing accuracy. If you have more than two insurances, please notify the front desk.

Primary Insurance Information		**Secondary Insurance Information**	
Insurance Name		**Insurance Name**	
Patient's Name on Insurance Card	**Plan/Group #**	**Patient's Name on Insurance Card**	**Plan/Group #**
Member ID Number	**Effective Date**	**Member ID Number**	**Effective Date**

Please read the following paragraph carefully and sign below.

The information provided above is true and accurate to the best of my knowledge.

I authorize payment directly to Adult and Pediatric Clinic, P.C. for the medical and/or surgical benefits payable to me by my insurance plans. I hereby agree to pay all charges that exceed and/or are not covered by my insurance. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default.

I hereby authorize Adult and Pediatric Clinic, P.C. to release information requested by my insurance company or Worker's Compensation Carrier. I also authorize Adult and Pediatric Clinic, P.C. to release information to any hospital or physician I may be referred to by this office. These records may be faxed, mailed or hand delivered."

* Signature of the patient or responsible party _____

* Today's Date: _____