Patient Demographic Sheet

Please print clearly

Last Name: ______________________ **First Name**: ______________________

Mailing Address: ______________________ City: ______________________

State: __________ Zip: __________ Gender: __________ Marital Status: __________

Primary Dr. ______________________ **Referring Dr.** ______________________

Employer: ______________________ **Occupation**: ______________________

Phone (Home):__________________ (Work) __________________ (Cell) __________________

Date of Birth: __________ SSN: ______________Email Address: ______________________

Emergency Contact:

1) Name __________________ Phone __________________ Relationship __________________

2) Name __________________ Phone __________________ Relationship __________________

☐ Check here if you authorize us to discuss your condition/treatment with the above contacts.

How did you hear about us?

☐ Employer ☐ Mail ☐ Friend ☐ Family Member ☐ Health Fair ☐ Insurance

☐ Physician ☐ Radio ☐ Website ☐ Yellow Pages ☐ Other______________

☐ Check if copies of insurance cards are attached; if not, please complete Insurance section below

Primary Insurance: ______________________ Policy ID #: ______________________

Policy Holder Name: ______________________ Group#: ______________________

Date of Birth: ______________ SSN: ______________ Employer: ______________________

Relationship to Patient: __☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other ______________

Address (if different from Pt): ____

City ______________ State: __________ Zip: __________

Are you covered by a secondary insurance? ☐ YES / ☐ NO

Secondary Insurance: ______________________ Policy ID #: ______________________

Policy Holder Name: ______________________ Group#: ______________________

Date of Birth: ______________ SSN: ______________ Employer: ______________________

Relationship to Patient: __☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other ______________

Address (if different from Pt): ____

City ______________ State: __________ Zip: __________