Patient Demographic Form

Patient Information

Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Please check all that apply: ☐ Male ☐ Female ☐ Employed ☐ Retired ☐ Other ☐ Married ☐ Single ☐ Other

Companion/Relative Name: _____ **Phone:** _____

Primary Doctor: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

Emergency Contact: _____

Would you like your results sent to your family doctor? ☐ Y ☐ N

How did you hear about us? Referred By: Doctor: _____ **Friend:**_____

Website: _____ **Mailing:** _____ **Other:** _____

Insurance Information – Please provide insurance card(s) with this completed form

Policy Holder's Name: _____ **Policy Holder's Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Insurance Company: _____ **Insured's ID#:** _____

Policy Group ID#: _____ **Social Security #:** _____

Insurance Plan Name/Program: _____ **Policy Holder's Relationship:** _____

Do you have Medicare Coverage? ☐ Y ☐ N (check one) **(**☐ self ☐ spouse ☐ child ☐ other)

Policy Holder's Employer Name: _____ **Phone:** _____

Secondary Insurance Information

Policy Holder's Name: _____ **Policy Holder's Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Insurance Company: _____ **Insured's ID#:** _____

Policy Group ID#: _____ **Social Security #:** _____

Insurance Plan Name/Program: _____ **Policy Holder's Relationship:** _____

Do you have Medicare Coverage? ☐ Y ☐ N (check one) **(**☐ self ☐ spouse ☐ child ☐ other)

Policy Holder's Employer Name: _____ **Phone:** _____