

PATIENT DEMOGRAPHIC SHEET

Last Name: _____ First Name: _____ MI: _____
 Address: _____ Apt. #: _____ City: _____
 State: _____ Zip: _____ Email: _____
 Home Tel. #: _____ Business Tel. #: _____
 Referring M.D.: _____ M.D.'s Tel. #: _____
 Doctor's Address: _____
 Date of Birth: _____ Sex: Male Female
 Marital Status: (CHECK ONE) Married Single Widow Divorced Separated
 Language: _____ Race: _____ Ethnicity: _____
 Mother's First Name: _____ Father's First Name: _____
 Employer: _____ Address: _____

AUTHORIZATION FOR RELEASE OF MEDICAL BENEFITS AND PAYMENT AGREEMENT

*****ALL PATIENTS (including Medicare Patients): PLEASE READ AND SIGN**

I verify the accuracy of the information provided on the Patient Demographic Sheet and authorize release of information necessary to process any claims. I also understand that this facility may not participate with my insurance and I am therefore responsible for payment. If my insurance is one that this facility participates in I request payment of claims directly to this facility. I understand that I am ultimately responsible for all services. Additionally, I will be responsible for all balances after insurance payments. I will work with the Doctor's office to have Worker's Compensation and/or No Fault claims paid to the Doctor, and I understand that all bills are my responsibility if not paid by the carrier.

Signature of Patient or Authorized Agent

Date

Print Name

Unit #

MEDICARE – SIGNATURE ON FILE

******ALL MEDICARE PATIENTS: PLEASE READ AND SIGN**

I request that payment of authorized Medicare benefits be made to my physician for any services furnished me by the physician. I authorize any holder of my medical information to release what is needed to determine these benefits or the benefits payable for related services to the Health Care Financing Administration and its agents.

Signature of Patient

Date

Print Name

Unit #