# Patient Demographics

Patient Name (Last, First): _____ Date of Birth: _____

Street Address: _____ Home Phone: _____

City, State, Zip: _____ Mobile Phone: _____

Email Address: _____ Social Security Number:_____

Marital Status: _____

Emergency Contact Name: _____ Phone Number: _____

Employer: _____Occupation: _____ Work Phone: _____

Primary Care Physician: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Pharmacy Name: _____

Street Address: _____

City, State, Zip: _____

Phone Number:_____

Primary

Insurance Company: _____ Name of Insured: _____

Street Address: _____ Relationship to Patient: _____

City, State, Zip: _____ Date of Birth (Insured): _____

Subscriber No.: _____ Group No.: _____

Co-Payment Amount: $_____ Effective Date: _____

Secondary

Insurance Company: _____ Name of Insured: _____

Street Address: _____ Relationship to Patient: _____

City, State, Zip: _____ Date of Birth (Insured): _____

Subscriber No.: _____ Group No.: _____

Co-Payment Amount: $_____ Effective Date: _____

Our office will bill your primary insurance only. You are responsible for the deductible, share-of-cost, and any costs not a benefit of your plan. Copayments are due at the time of your visit. An administrative fee of $30.00 will be charged for each co-payment not made at the time of service. If you do not have insurance, payment is expected at the time of your visit. A missed appointment fee of $75.00 will be charged for all appointments not cancelled 24 hours in advance.

I authorize the release of any information necessary to process claims with my insurance. I authorize payment of medical benefits be made directly to the physician/provider for services rendered.

I understand it is my responsibility to know whether Dr. Phelps-Sandall is a member of my insurance. If she is not, I will be responsible for payment in full.

Signature:_____ Date: _____