Patient Demographics - Insurance Consent

Legal Name ____________________ SS# _____/____/_____ Age _____
Cell Phone (_____)________________ Work Phone (_____)________________ Date of Birth ____________________
Address ____________________ Apt# ____________________
City ________________________ State _________ Zip __________
Email Address ____________________
Pharmacy: Name ________________________________ Location ________________________________

Preferred Language: ________________________
Race: White / Black or African American / Asian / American Indian or Alaskan Native / Native Hawaiian or other Pacific Islander/ Other Race
Ethnicity: Hispanic or Latino / Non-Hispanic or Latino
Marital Status: Single / Engaged / Married / Divorced / Widowed / Domestic Partner / Separated
What is your sexual orientation? Heterosexual / Homosexual / Bisexual / Other / Do not wish to state
What is your gender? Female / Male / Non-binary / _______________
What gender were you assigned at birth? Female / Male
Do you identify as transgender? Yes / No / Prefer not to say
Preferred Pronouns: (She/her/hers) (He/him/his) (They/them/theirs)

EMERGENCY CONTACT
Name ____ Relationship to Patient _________________________
Cell Phone (_____)_______________ Work Phone (_____)_______________
Address ____________________ Apt# ___________________
City ________________________ State _________ Zip __________

PARENT/GUARDIAN IF PATIENT IS A MINOR OR DEPENDENT
Name ____ Relationship to Patient _________________________
Cell Phone (_____)_______________ Work Phone (_____)_______________
Address ____________________ Apt# ___________________
City ________________________ State _________ Zip __________

INSURANCE INFORMATION
Primary Insurance ___________________________________ Policy # ___________________ Group # ____________
Patient's Relationship to Insured
☐Self ☐Spouse ☐Child ☐Other________ Name of Subscriber (if other than patient) _____________ DOB _________
Secondary Insurance ___________________________________ Policy # __________________ Group # ___________
Patient's Relationship to Insured
☐Self ☐Spouse ☐Child ☐Other________ Name of Subscriber (if other than patient) _____________ DOB _________

By signing below, I acknowledge that if I do not provide complete and correct insurance information, I assume personal financial responsibility.

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. **Physician Insurance Assignment:** I, the below named subscriber, hereby authorize payment direct to any physician examining or treatment of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge of these services.

II. **Medicare/Medicaid:** Patient's certification authorization to release information and payment request. I certify that the information given by me applying or payment under Title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediate or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

III. I permit a copy of these authorization and assignments to be used in place of the original which is on file at the physician's office. If Medicare patient, I understand this is a lifetime authorization.

I agree that should the amount of the insurance benefits be insufficient to cover the expenses, I will be responsible for payment of the difference. I will be responsible for the entire amount due for professional services rendered if the expense is not covered by my policy.Note: You will receive a separate bill for outside lab, physician or hospital for interpretation of results of lab work and/or pathology specimens collected in our office.

PATIENT SIGNATURE ____ Date ___________________________

ORIGINAL SIGNATURE ON FILE AT PHYSICIANS OFFICE
ALL MEDICAL SERVICES PAYABLE AT THE TIME THE SERVICE IS RENDERED