DATE _____ PATIENT DEMOGRAPHIC WORKSHEET

A

| First NAME LAST NAME | MARITAL STATUS | DATE OF BIRTH | SEX | SOCIAL SECURITY # |
|---|---|---|---|---|
| | | | | |

| STREET ADDRESS APT | CITY AND STATE | ZIP CODE | PRIMARY PHONE NUMBER |
|---|---|---|---|
| | | | |

| DRIVER'S LICENSE NUMBER | PHARMACY NAME AND NUMBER | SECONDARY PHONE |
|---|---|---|
| | | |

| PATIENT EMPLOYER | OCCUPATION | OTHER PHONE |
|---|---|---|
| | | |

| EMPLOYER STREET ADDRESS | CITY AND STATE | ZIP CODE |
|---|---|---|
| | | |

| EMERGENCY CONTACT (SEE HIPPA FORM) | RELATIONSHIP TO PATIENT | EMERGENCY CONTACT PHONE |
|---|---|---|
| | | |

| Do you Have an Advance Directive? also known as living wills, or advance decisions | YES NO | Do you have any barriers to care? | Please Circle => Language Auditory Visual Cultural |
|---|---|---|---|
| | | | |

B

| DO YOU WANT YOUR VISITS SUBMITTED TO YOUR INSURANCE COMPANY? | YES | NO |
|---|---|---|
| | | |

**IF YES SKIP TO SECTION C**

**$100 OFFICE VISIT ONLY FOR PATIENTS WHO WISH TO PAY OFFICE AT TIME OF SERVICE.**

**WE WILL NOT BE RESPONSIBLE FOR SUBMITTING CLAIMS. $100 IS FOR VISIT ONLY ADDITIONAL FEES MAY APPLY**

I UNDERSTAND THAT I HAVE ELECTED TO MAKE PAYMENT FOR SERVICES DIRECTLY TO FIRST HEALTH AND I HAVE NOT PROVIDED PROOF OF INSURANCE COVERAGE AND UNDERSTAND FIRST HEALTH WILL NOT SUBMIT ANY CLAIM FOR PAYMENT OF SERVICES

SIGNATURE _____ DATE _____

C

## COMPLETE BELOW ONLY IF YOU ANSWERED "YES" IN SECTION B

| INSURANCE COMPANY | ID # |
|---|---|
| | |

| INSURED NAME | INSURED DATE OF BIRTH |
|---|---|
| | |

**I WILL BE RESPONSIBLE FOR CHANGING THE PCP (PRIMARY CARE PHYSICIAN) IF NECESSARY. I AGREE TO PAY ANY ADDITIONAL CHARGES OR COPAYS IN THE EVENT THE REQUIRED CHANGE WAS NOT MADE.**

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM.

I ALSO REQUEST PAYMENT OF BENEFITS TO BE MADE TO THE OFFICE DIRECTLY.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR INSURANCE BENEFITS BE MADE ON MY BEHALF TO THE OFFICE.

I AUTHORIZE THE RELEASE OF ANY AND ALL INFORMATION TO THE INSURANCE COMPANIES AND ITS AGENTS ANY INFORMATION NEED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES

I assign directly to my provider all insurance benefits otherwise payable to me for services rendered and authorize the use of this sign

SIGNATURE _____ DATE _____