

# Patient Demographic Form

Please PRINT



Date

PATIENT INFORMATION			
LAST NAME	FIRST NAME	MI	Nickname/ Maiden
DATE OF BIRTH	SOCIAL SECURITY NUMBER	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	
MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Life Partner <input type="checkbox"/> Separated			
HOME ADDRESS	CITY	STATE and ZIP CODE	
HOME PHONE	WORK PHONE	CELL PHONE	
EMPLOYMENT STATUS <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Homemaker <input type="checkbox"/> Not Employed <input type="checkbox"/> Retired <input type="checkbox"/> Self Employed <input type="checkbox"/> Student Full-Time <input type="checkbox"/> Student Part-Time <input type="checkbox"/> Active Duty Military <input type="checkbox"/> Child <input type="checkbox"/> Disabled <input type="checkbox"/> Other			
EMPLOYER			
EMPLOYER ADDRESS and PHONE NUMBER			

PHYSICIAN REFERRAL INFORMATION	
PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN

RESPONSIBLE PARTY (GUARANTOR) INFORMATION		
POLICY HOLDER NAME (LAST, FIRST, MI)	RELATION TO PATIENT	
POLICY HOLDER DATE OF BIRTH	POLICY HOLDER SOCIAL SECURITY NUMBER	
POLICY HOLDER HOME ADDRESS	CITY	STATE and ZIP CODE
POLICY HOLDER HOME PHONE	POLICY HOLDER WORK PHONE	POLICY HOLDER CELL PHONE
POLICY HOLDER EMPLOYER	POLICY HOLDER EMPLOYER ADDRESS	POLICY HOLDER EMPLOYER PHONE No.
POLICY NUMBER	GROUP NUMBER	

SUPPLEMENTAL INSURANCE INFORMATION		
POLICY HOLDER NAME (LAST, FIRST, MI)	RELATION TO PATIENT	
POLICY HOLDER DATE OF BIRTH	POLICY HOLDER SOCIAL SECURITY NUMBER	
POLICY HOLDER HOME ADDRESS	CITY	STATE and ZIP CODE
POLICY HOLDER HOME PHONE	POLICY HOLDER WORK PHONE	POLICY HOLDER CELL PHONE
POLICY HOLDER EMPLOYER	POLICY HOLDER EMPLOYER ADDRESS	POLICY HOLDER EMPLOYER PHONE No.
POLICY NUMBER	GROUP NUMBER	

EMERGENCY CONTACT INFORMATION			
LAST NAME	FIRST NAME	Phone Number	Relationship to Patient
HOME ADDRESS	CITY	STATE and ZIP CODE	

I certify that I, and/or my dependant(s), have insurance as indicated above and authorize all insurance benefits payable to Dr. David Spivey and Preferred Pain Management. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I authorize the use of my signature on all insurance submissions.

I authorize Dr. David Spivey and Preferred Pain Management to disclose my healthcare information to the above named insurance company(ies) and their agents for the purpose of determining benefits and payment for related services. This consent is will end when my treatment plan is complete or one year from the date indicated below.

SIGNED:

DATE: