Patient Demographic Form

Please PRINT

Date

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	Nickname/ Maiden

DATE OF BIRTH	SOCIAL SECURITY NUMBER	GENDER □ Male □ Female

MARITAL STATUS □ Married □ Single □ Divorced □ Life Partner □ Separated

HOME ADDRESS	CITY	STATE and ZIP CODE

HOME PHONE	WORK PHONE	CELL PHONE

EMPLOYMENT STATUS
□ Employed Full-Time □ Employed Part-Time □ Homemaker □ Not Employed □ Retired □ Self Employed □ Student Full-Time □ Student Part-Time
□ Active Duty Military □ Child □ Disabled □ 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:**