# DEMOGRAPHIC FORM

(Please Print)

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|---|---|---|---|---|---|---|
| Today's date: | | | | | | |
| **PATIENT INFORMATION** | | | | | | |
| Patient's last name: First: Middle: | | | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid | |
| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F | |
| Street address: | | Social Security no.: | | Home phone no.: ( ) | | |
| P.O. box: | City: | State: | ZIP Code: | | | |
| Occupation: | Employer: | Employer phone no.: ( ) | | | | |
| Chose clinic because/Referred to clinic by (please check one box): | | | | | | |
| ❑ Family | ❑ Friend | ❑ Close to home/work | ❑ Yellow Pages | ❑ Other | | |
| Other family members seen here: | | | | | | |

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| **INSURANCE INFORMATION** | | | | | |
| Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( ) | | |
| Is this person a patient here? ❑ Yes ❑ No | | | | | |
| Occupation: | Employer: | Employer address: | Employer phone no.: ( ) | | |
| Is this patient covered by insurance? ❑ Yes ❑ No | | | | | |
| Name of primary insurance: | Subscriber's name: | Group no.: | Policy no.: | | |
| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $ |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | |
| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: | | |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | |

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| **IF APPLYING FOR A FINANCIAL HARDSHIP DISCOUNT:** |
| I state that there are _____ people living in my household and the combined household income is $ _____ per (circle one): week every 2 weeks month year |
| Do your currently receive any public financial assistance such as WIC, SNAP, or TANF? Circle one: Yes No |

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| **AUTHORIZATIONS AND AGREEMENTS** | | | |
| **Emergency Contact:** Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |

The above information is true to the best of my knowledge. I request and authorize the Practice and its personnel to deliver medical care to me or my child listed above. I further authorize my insurance benefits be paid directly to the provider. I have received the Patient Financial Policies and understand that I am financially responsible for any balance. I also authorize Morrow County Health District or insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*

**September 2014**