



Date: \_\_\_\_\_

My Appointment is with Dr. \_\_\_\_\_

**PATIENT DEMOGRAPHIC WORKSHEET**

<b>PATIENT</b>	PATIENT NAME		MARITAL STATUS	SEX	AGE	DATE OF BIRTH	
	HOME PHONE	MOBILE PHONE	EMAIL ADDRESS		SSN		
	STREET ADDRESS		APT/SUITE#		CITY AND STATE		ZIP
	Employer Name City and State		WORK PHONE		Emergency Contact Name and Number		
<b>RESP PARTY</b>	RESP PARTY NAME		OCCUPATION(INDICATE IF STUDENT)		HOME PHONE		
	RELATIONSHIP TO PATIENT		PATIENT TYPE		WORK PHONE		
	STREET ADDRESS		APT/SUITE #		CITY AND STATE		ZIP CODE

**INSURANCE INFORMATION**

<b>INSURANCE</b>	(CIRCLE ONE)    MEDICARE    MEDICAID    HMO    PPO    EPO    POS    PRIVATE    NONE    OTHER: _____						
	PRIMARY INSURANCE		EFFECTIVE DATE		ID / GROUP NUMBER		
	POLICY HOLDER NAME		RELATIONSHIP TO PATIENT		DATE OF BIRTH		SOCIAL SECURITY NUMBER
	SECONDARY INSURANCE		EFFECTIVE DATE		ID / GROUP NUMBER		
	POLICY HOLDER NAME		RELATIONSHIP TO PATIENT		DATE OF BIRTH		SOCIAL SECURITY NUMBER

**FINANCIAL POLICY STATEMENT**

I hereby authorize and direct Primary Health Associates and any member physician having treated me or my dependent, to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

I understand that I am responsible for all co-pays, co-insurance and deductible amounts as set forth by my insurance carrier.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

**I understand that any personal outstanding balance that is 30 days or more past due will be subject to a finance charge of 1.5% per mo. (APR 18%).**

In the event my account is placed in collection status I will be responsible for all collection costs incurred, including attorney fees and court costs should I be referred for litigation.