Patient Demographic Form

Patient Name: _____ **Date of Birth:** _____

First M Last

Social Security #: _____ **Gender:** Male/Female **Martial Status:** S/M/W/D

Race:_____ Ethnicity: Hispanic/Latino or Non-Hispanic/Latino **Language**:_____

Address: _____**City:** _____

State: _____ **Zip** _____ **Email:** _____

Home Phone #: _____ **Cell #**: _____

Employer: _____ **Work#** _____

Spouse

Name: _____ **Date of Birth:** _____

Social Security #: _____ **Spouse #** _____

Employer: _____ **Work #** _____

If the patient is a Minor/Student

Mother's Name: _____ **Date of Birth:** _____

Address: _____**City:** _____

State: _____ **Zip** _____ **Email:** _____

Home Phone #: _____ **Cell #**: _____

Father's Name: _____ **Date of Birth:** _____

Address: _____**City:** _____

State: _____ **Zip** _____ **Email:** _____

Home Phone #: _____ **Cell #**: _____

Emergency

Name/Relationship Phone Allowed to talk about:

_____ Medical Financial

_____ Medical Financial

_____ Medical Financial

Insurance Information

Primary

Insurance Co: _____ Policy Holder/Relationship _____

Policy Holder's D.O.B _____ Policy Holder's SSN _____

Secondary

Insurance Co: _____ Policy Holder/Relationship _____

Policy Holder's D.O.B _____ Policy Holder's SSN _____

Financial Agreement

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure that payment for services render is received. I understand that I am ultimately responsible for payment of all services. I will pay any unpaid balance by cash, check or credit card (VISA/MASTERCARD/DISCOVER). For accounts to stay in good standing, a payment must be made **every 30 days.** Every effort will be made to work with our patients on delinquent accounts, but if the account is in default it will be turned over to a collection company where you could be responsible for collection effort fees, including interest, attorney fees and court costs.

_____ _____ _____

Print name of Patient/Parent/Guardian Signature of Patient/Parent/Guardian Date

Insurance Authorizations

I hereby authorize any insurance company to pay the proceeds of any assigned benefits directly to Jeffrey S. Stevens D.P.M. I authorize Jeffrey S. Stevens D.P.M. to release any medical information necessary to process insurance claims on my behalf. A copy of this can be considered as an original for insurance purpose.

Signed _____ Date _____

I understand I am responsible for meeting the requirements of my insurance policy. I understand any charges not paid by my insurance are my responsibility and will be responsible for any collection or legal fees necessary to collect said charges.

Signed _____ Date _____