NEW PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

NAME			SSN#	BIRTHDATE	SEX
ADDRESS			HOME PHONE	CELL PHONE	
CITY, STATE, ZIP			EMPLOYMENT STATUS ☐FULL TIME? HIRE DATE_____________ ☐DISABLED? DATE OF DISABILITY ____________ ☐PART TIME? END DATE______________ ☐RETIRED? DATE OF RETIREMENT ____________		
MARITAL STATUS		SPOUSE'S NAME	EMPLOYER		
SPOUSE'S DOB		SPOUSE'S PHONE	MAY WE CONTACT YOU AT WORK? YES ☐ NO ☐ WORK PHONE ______________________		
LANGUAGE		ETHNICITY ☐HISPANIC OR LATINO ☐NOT HISPANIC OR LATINO ☐DECLINE TO ANSWER ☐UNKNOWN	PRIMARY CARE PROVIDER		
RACE	RELIGION		EMAIL ADDRESS		

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)

NAME		SSN#	BIRTHDATE	SEX
ADDRESS		RELATIONSHIP TO PATIENT	EMPLOYER	
CITY, STATE, ZIP		EMPLOYMENT STATUS ☐FULL TIME? HIRE DATE_____________ ☐DISABLED? DATE OF DISABILITY ____________ ☐PART TIME? END DATE______________ ☐RETIRED? DATE OF RETIREMENT ____________		
HOME PHONE	CELL PHONE	WORK PHONE	MAY WE CONTACT YOU AT WORK? YES ☐ NO ☐	

PRIMARY INSURANCE	**SECONDARY INSURANCE**
NAME OF INSURANCE COMPANY	NAME OF INSURANCE COMPANY
POLICY #	POLICY #
EMPLOYER	EMPLOYER
GROUP#	GROUP#

EMERGENCY CONTACT			**ALTERNATE EMERGENCY CONTACT**		
NAME	BIRTHDATE	RELATION	NAME	BIRTHDATE	RELATION
ADDRESS			ADDRESS		
CITY, STATE, ZIP			CITY, STATE, ZIP		
HOME PHONE	CELL PHONE		HOME PHONE	CELL PHONE	

I hereby authorize the release of any information to all claims for benefits submitted on behalf of myself and/or my dependents. I hereby acknowledge that my signature on this document authorized my physician to submit claims for benefits or services rendered without obtaining signature on each claim submitted for myself and/or my dependents. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits will be credited to my account. Permission is given to ST. MARIES FAMILY MEDICINE and associates to render the proposed examination and treatment. Payment is required for services unless other arrangements have been made in advance.

X____ DATE ____

SIGNATURE OF PATIENT OR GUARDIAN