PATIENT DEMOGRAPHIC VERIFICATION FORM

		UPDATE INFORMATION BELOW
Responsible Party		
Name		
Address		
Phone Number		
Patient Information		
Name		
Mailing Address		
Alternate/Local Address		
Phone Number		
Cell Phone Number		
Email Address		
Date of Birth		
Patient Sex		
Marital Status		
Age		
Social Security Number		
Emergency Name		
Emergency Phone		
Preferred Language		
Race:	❑ American Indian or Alaskan Native ❑ Asian ❑ Native Hawaiian or other Pacific Islander ❑ Black or African American ❑ White ❑ Other Race ❑ Unreported/Refused to Report	
Ethnicity (Cultural Background)	❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Refused to Report	
Have you received medical care from any other healthcare provider since your last visit in our office?	❑ Yes ❑ No	
Do you have an Advanced Directive? ❑ Yes ❑ No | ❑Living Will ❑ Organ Donor ❑DNR ❑ Power of Attorney ❑ Other		
Employer Information		
Name of Employer		
Employer Address		
Employer Phone Number		
Health Insurance		
Primary Insurance Name	--	
Primary Claim Address		
Primary Phone Number		
Primary Policyholder		
Primary Subscriber Number	--	
Primary Group Number		
Secondary Insurance Name	--	
Secondary Subscriber Number	--	
Secondary Group Number		
Pharmacy Information		
Pharmacy Name		
Pharmacy Address		
Pharmacy Phone Number		

I certify the above demographic and insurance information listed above to be correct. I hereby authorize any insurance benefits to be paid directly to the physician providing services and recognize my responsibility to pay for all non-covered services. I also authorize the physician to release any information necessary to process an insurance claim

X	**Date**