FAMILY PRACTICE DOCTORS

Demographic Face Sheet Form

Patient's Name (Last)_____ (First)_____ (M.I. _____)

SS# _____ Date of Birth ____/____/____ Sex: M / F Marital Status _____

Home Address _____ Apt# _____

City _____ State _____ Zip Code _____

Home # _____ Work # _____ Cell # _____

Race: Asian / White / Hispanic / African American / Other / Refuse

Email Address: _____

How did you hear about our office? Friend / Family / Internet / Paper / Other _____

Primary Insurance Information

Policyholder Name _____ Date of Birth ____/____/____ SS# _____

Insurance Name _____

Policy # _____ Group # _____

Relationship to Policyholder: Self / Spouse / Child / Other _____

Employer Name _____

Address _____ City _____ State _____ Zip _____

Secondary Insurance Information

Policyholder Name _____ Date of Birth ____/____/____ SS# _____

Insurance Name _____

Policy # _____ Group # _____

Relationship to Policyholder: Self / Souse / Child / Other _____

Employer Name _____

Address _____ City _____State _____ Zip _____

Name of emergency Contact _____ Phone _____ Relationship_____

I authorize the release of any previous results, images, or medication usage in the event it is needed to help with the diagnosis and plan of care for further treatment. I permit a copy of this authorization to be used in place of the original. I understand and acknowledge that I am personally responsible for the services rendered at this facility. We will bill your insurance carrier as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

(Patient signature/ Guardian) **X**_____ Date _____