PATIENT DEMOGRAPHIC

PATIENT INFORMATION

PATIENT NAME: _____
FIRST MIDDLE LAST

DATE OF BIRTH: _____ / _____ / _____ GENDER: ☐ FEMALE MALE ☐

SOCIAL SECURITY NO.: _____ EMAIL: _____

CELL NO.: _____ - _____ - _____ WORK NO.: _____ - _____ - _____ HOME NO.: _____ - _____ - _____

HOME ADDRESS: _____
APT/UNIT # CITY STATE ZIP CODE

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED OTHER: _____

RACE (CIRCLE ONE): WHITE / AFRICAN AMERICAN / ASIAN / AMERICAN INDIAN / OTHER: _____

ETHNICITY (CIRCLE ONE): HISPANIC / NON-HISPANIC LANGUAGE (CIRCLE ONE): ENGLISH / SPANISH / FRENCH / OTHER: _____

OCCUPATION: _____ EMPLOYER: _____

NAME OF EMERGENCY CONTACT: _____ DOB: _____ / _____ / _____
FIRST LAST

RELATIONSHIP: _____ PHONE NO.: (_____) _____ - _____

INSURANCE INFORMATION

SUBSCRIBER'S NAME (IF DIFFERENT FROM PATIENT) _____
FIRST MIDDLE LAST

SUBSCRIBER ID: _____ **CO – PAY:** _____

DATE OF BIRTH: _____ / _____ / _____ PHONE NO.: (_____) - _____ - _____ RELATIONSHIP TO PATIENT: _____

RESPONSIBLE PARTY INFORMATION (ONLY IF DIFFERENT FROM PATIENT)

RESPONSIBLE PARTY NAME: _____ DATE OF BIRTH: _____ / _____ / _____

RELATIONSHIP: _____ HOME NO.: (_____) _____ - _____ CELL NO.: (_____) _____ - _____

MAILING ADDRESS: _____
APT/UNIT # CITY STATE ZIP CODE

FINANCIAL DISCLOSURE

I hereby authorize and direct my insurance carrier(s) to issue payment to **Elizabeth Salada M.D.** for medical services rendered. **I understand that I am responsible for any amount not covered by my insurance. I hereby authorize Dr. Elizabeth Salada to release all information necessary to secure payment of benefits.**

PATIENT SIGNATURE: _____ DATE: _____