

Patient Demographic Sheet

Patient Name _____ Birth Date _____ Age _____
Address _____ SSN _____ M _____ F _____
_____ Marital Status _____ Spouse Name _____
Home Phone # _____ Work Phone # _____ Spouse's BirthDate _____
Cell Phone# _____ E-Mail Address _____
Employer _____ Address _____

Referring Doctor _____ Family Doctor _____
Address _____ Address _____
_____ _____
Phone # _____ Fax # _____ Phone # _____ Fax # _____

Date of: (complete one) Auto Accident _____ State _____ Work related injury _____

Emergency Contact Person:
Phone: () _____

Primary Insurance

See copy of insurance card(s)

Name of Company _____

Mail to: _____

Phone: _____

Policyholder: _____

Policyholder's Birth Date: _____

Employer: _____

Policy/Claim #: _____

Group #: _____

Secondary Insurance

Name of Company _____

Mail to: _____

Phone: _____

Policyholder: _____

Policyholder's BirthDate: _____

Employer: _____

Policy/Claim #: _____

Group #: _____

I authorize the release of any medical information necessary to process insurance claims and I request payment of all medical benefits to be paid directly to PRISM for services provided. If I have paid the bill myself, I will be given paperwork to submit to my insurance company for reimbursement directly to me. I also authorize release of my medical records to all clinicians involved in my care.

I UNDERSTAND OTHER REQUESTS FOR RECORD RELEASE WILL REQUIRE A FULLY COMPLETED **HIPAA** COMPLIANT AUTHORIZATION. FULL DETAILS OF RECORD RELEASE ARE DEFINED IN PRISM NOTICE OF PRIVACY.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT PROMPTLY PAID BY INSURANCE CARRIERS.

Signature _____ Date _____ Updated _____