NORTHWEST
MEDICAL GROUP

Patient Demographic Form

Appointment Date: _____
Time: _____
Reason:_____

Last Name:_____First Name:_____MI: _____

Date of Birth (MM/DD/YYYY): _____ ☐ Female ☐Male

Patient SS#: _____ ☐Married ☐Single

Mailing Address:_____ Apt #:__ City:_____State:__ Zip: _____

Drivers License #: _____

State: _____ Class (If applicable): ☐ A ☐ B ☐ C ☐ D ☐ Other

Please check preferred method of contact

☐ Home Phone: _____ ☐ Cell phone:_____

Patient Email Address: _____

For security of your records, all emails containing protected health information (PHI) are sent encrypted.

Emergency Contact Name:_____ Emergency Contact Phone: _____

Relationship to patient: (Check one) ☐Self ☐Spouse ☐Parent/Guardian ☐Other: _____

Employer Name: _____ Employer Address: _____

Employer Supervisor: _____

Supervisor Phone: _____ Supervisor Email: _____

Northwest Medical Group's external survey partner may contact you to participate in a satisfaction survey about this visit. We rely on your feedback to help us improve the patient experience. May we contact you for a brief survey? ☐Yes ☐No

Northwest Medical Group will submit claims to my insurance carrier as well as medical records needed to evaluate the claims for payment. I further assign payment of benefits, otherwise payable to me, to be made payable to Northwest Medical Group. By providing my signature below, I understand that I am financially responsible for all charges not covered by my insurance.

Print Name: _____

Signature:_____ Date: _____