

***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.

I understand that I am financially responsible for all charges not covered by my insurance.

**Print Name:**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_