Lincoln Park Family Physicians SC

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PATIENT DEMOGRAPHIC FORM

☐PATIENT INFORMATION

First Name: ________________________________ Last Name: ____________________________ Sex: ☐M ☐F

Address: ____City:_______________State:____Zip:_________

Home Phone: ____________________Work Phone: ____________________ Cell Phone: _______________________

Birth date: ____________________ Marital Status: ☐Single ☐Married ☐Other

Social Security: ________________________________ Maiden Name: __________________________

Race: _______________________ Language Preference: _______________ Ethnicity: _________________________

Email Address: ____

☐INSURANCE INFORMATION (Must be filled out if Patient is not the policyholder)

PRIMARY INS Co. Name: ____

Member ID: _______________________________________ Group: ______________________________________

Policyholder's Name: ____ Sex: ☐M ☐F

Address: _____________________________________City:______________________ State: ____ Zip: ___________

Birth Date: ________________ Phone: ____________________ Relationship to Patient: _______________________

SECONDARY INS Co. Name: ____

Member ID: ____ Group: ____________________________________

Policyholder's Name: ____ Sex: ☐M ☐F

Address: _____________________________________City:______________________ State: ____ Zip: ___________

Birth Date: ______________ Phone: ______________________ Relationship to Patient: __________________________

☐EMERGENCY CONTACT

Name: ____ Phone: __________________________

Relationship to Patient: ____

☐PHARMACY

Local: _________________________________Phone:_________________________Fax:_________________________

Mail Order: _____________________________Phone:_________________________Fax:_________________________

Our billing office is pleased to file your insurance claim as a courtesy to you with the insurance company listed above. The Patient is responsible for all co-insurance, co-pays, and deductibles and denied services billable to the patient per their contractual obligations. We will bill all commercial insurance companies as long as you provide us with the necessary and most up to date information at time of service.

If your insurance cannot be verified you will be self-pay at time of service.

By signing below I acknowledge that I consent to and understand Lincoln Park Family Physicians Notice of Patient Responsibilities. I hereby authorize payment directly to Lincoln Park Family Physicians for benefits otherwise payable to me. In the event my insurance company forwards payment directly to me, I will deliver such payment to Lincoln Park Family Physicians. I understand that I am financially responsible for charges not covered by this authorization. If my account balance is referred to an outside agency for collections, all cost will be added to my current balance at the time of placement. I also authorize Lincoln Park Family Physicians to release any information acquired in the course of my examination or treatment in the processing of these claims.

PATIENT/GUARDIAN SIGNATURE: ____**DATE:**__________________