PATIENT DEMOGRAPHICS SHEET

To bill your insurance we require a copy of your insurance and ID card before each visit

Patient Name: _____ Date of Birth: _____
Last First Middle

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____ Email: _____

Primary Care Physician (PCP): _____

Street Address: _____ Phone # :(_____) _____-_____

City: _____ State: _____ Zip: _____

Referring physician (*if different from PCP*): _____Phone: (____) _____-_____

How did you hear about our office (*if not from a doctor*)? _____

Preferred Pharmacy and Location: _____

As a result of continued efforts by the Centers of Medicare & Medicaid Services (CMS) there are currently a total of 17 standards Healthcare Providers are required to meet in order to be eligible for full reimbursement for rendered services. This information is required because it can aide providers in diagnosing certain diseases. Thank you for providing us with this information as it will assist us in our continued efforts to provide the best possible service and care.

Occupation: _____ Employer: _____

If retired, date retired: _____Marital Status: _____ Sex: _____

Ethnicity: _____Race: _____ Religion: _____

☐ I Prefer not to answer