Between the Bridges Healing Center

PATIENT DEMOGRAPHIC FORM

Today's Date_____

PATIENT INFORMATION

Patient Name: _____ Social Security No.: _____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Sex: M F Marital Status: Single Married Widow/er Divorced Partner

Mailing Address: _____
Street Apt. No. City State Zip

Physical Address (if not same as mailing): _____
Street City State Zip

Home Phone: (_____) _____ - _____ Cell/Pager No.: (_____) _____ - _____ May we leave a message? Y N

E-Mail Address: _____

Spouse Name: _____ Date of Birth: _____/_____/_____ Social Security No.: _____/_____/_____

Address: _____ Work Phone: (_____) _____ - _____

Emergency Contact Name: _____ Emergency Contact Phone: (_____) _____ - _____

Address: _____ Relationship: _____

Employer: _____Occupation:_____

Address: _____ Work Phone: (_____) _____ - _____

GUARANTOR/PARENT INFORMATION

Responsible Party Name: _____ DOB: _____/_____/_____ Social Security No.: _____/_____/_____

Address: _____ Home Phone: (_____) _____ - _____

Employer: _____ Work Phone: (_____) _____ - _____

Relationship to Patient: _____ Cell/Pager No.: (_____) _____ - _____

PATIENT'S INSURANCE INFORMATION ** Please provide Insurance Card and Photo ID/Driver's License to Receptionist**

Primary Insurance Company's Name:_____

Insurance Address:_____
Street Suite No. City State Zip

Name of Policy Holder: _____ Date of Birth: _____/_____/_____ Social Security No.: _____/_____/_____

Insurance ID No.: _____ Insurance Group No.: _____

Secondary Insurance Company's Name: _____

Insurance Address: _____
Street Suite No. City State Zip

Name of Policy Holder: _____ Date of Birth: _____/_____/_____ Social Security No.: _____/_____/_____

Insurance ID No.: _____ Insurance Group No.: _____

PATIENT'S REFERRAL INFORMATION

Referred By (circle or fill in): Family Friend Hospital Radio Health Care Provider Name: _____

Primary Care Provider: _____ Referring Provider: _____

(Please Read and Sign)

I understand that I am responsible for all charges incurred on my behalf, including any added costs incurred due any effort to collect for services rendered.

Responsible Party: _____ Date: _____