PATIENT DEMOGRAPHIC SHEET

Patient Name: _____ Sex ____ Age____
Last First Middle

Street Address: _____ City: _____

State: _____ Zip: _____ Date of Birth: _____

Former primary care doctor: _____ Referred by: _____

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

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

Occupation: _____ Employer: _____

Marital status: _____ Spouse's name (if applicable): _____

Spouse's employer (if applicable): _____

IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT?

Name: _____ Home: (____) ____-_____

Relationship: _____ Cell: (____) _____ - _____

HEALTH INSURANCE INFORMATION

Primary Insurance _____ Subscriber Name/DOB _____

ID# _____ Group # _____Social Security # _____

Secondary Insurance _____ Subscriber Name/DOB _____

ID# _____ Group # _____ Social Security # _____

PRIVATE INSURANCE AND MEDICARE ASSIGNMENT OF BENEFIT

I authorize the release of any medical or other information necessary to process any claims. I also request that payment of benefits be paid directly to Dr. Joyce Tatelman. I understand that, if I am not contracted with any insurance, I am required to pay for all charges at the time of service. All co-pays are also due at the time of service. I have read and understand these policies and by signing below acknowledge agreement with them. All appointments missed or cancelled with less than 24-hour notice will be assessed a $45 fee for an office visit, and a $75 fee for a physical.

PATIENT SIGNATURE _____ DATE _____