PATIENT DEMOGRAPHIC FORM

LAST NAME:		FIRST NAME:	M.I.
D.O.B:	GENDER: ❑ Male ❑ Female ❑ Transgender	MARITAL STATUS: ❑ Single ❑ Married ❑ Divorced ❑ Widowed	

SOCIALSECURITY NO.	PREFERRED LANGUAGE: ❑ English ❑ Other ❑ Indian ❑ Spanish ❑ Russian
RACE: ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian/Other Pacific ❑ Black or African American ❑ White ❑ Hispanic ❑ Other Race	ETHNICITY: ❑ Hispanic or Latin ❑ Not Hispanic or Latin ❑ Refuse to Report

HOME ADDRESS:	CITY	STATE	ZIP

HOME PHONE:	CELL:	EMAIL:

EMPLOYER:	WORK PHONE:

ALLERGIES (Medical Alert):

PRIMARY CARE PHYSICIAN:	PHONE:	REFERRING PHYSICIAN:

PHARMACY NAME:	ADDRESS:

CITY:	STATE:	ZIP:

IN CASE OF EMERGENCY CONTACT

FIRST NAME:	LAST NAME:	RELATION:	PHONE:

INSURANCE INFORMATION: PRIMARY

Insured Name:	Relationship to Patient:	DOB:
Insurance Company:		
Insurance Company Address:		

City:	State:	ZIP:	Phone:
Policy No:	Group No:		Employer:

INSURANCE INFORMATION: SECONDARY

Insured Name:	Relationship to Patient:	DOB:
Insurance Company:		
Insurance Company Address:		

City:	State:	ZIP:	Phone:
Policy No:	Group No:		Employer:

STATEMENT OF FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFIT: I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of the Doctors Pain Clinic or Doctors Pain Center, LLC. I assign and authorize payments to Doctors Pain Clinic or Doctors Pain Center, LLC. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or state or federal law. **I give permission to leave phone message(s): YES NO**

Patient Signature and/or Guardian Date

Revised 3.14.2012