PRIME HealthCare, PC

Patient Demographic Form

www.primehc.com

Patient Last Name	Patient First Name	MI	Date of Birth	SEX ☐ Female ☐Male ☐ Other: ___________

Social Security #	Email Address	Marital Status ☐S ☐M ☐D ☐W

Employment Status: ☐Employed ☐Retired ☐Self-Employed ☐Part-Time Student ☐Full-Time Student ☐Disabled ☐Unemployed

The Federal Government asks providers to ask the questions below.

Race	Ethnicity	Language
☐Caucasian ☐Black ☐Asian ☐Native Indian / Native Alaskan ☐Native Hawaiian / Pacific Islander ☐ Other Race ☐Unknown	☐Hispanic/Latino ☐Not Hispanic/Latino ☐Caucasian ☐Other ☐Unknown	☐English ☐Spanish ☐French ☐Polish ☐Vietnamese ☐Sign ☐Other

Home Address	City	State	Zip Code
Billing / Mailing Address	City	State	Zip Code

Preferred Phone: ☐Home ☐Cell ☐Work	Additional Phone: ☐Home ☐Cell ☐Work	Additional Phone: ☐Home ☐Cell ☐Work
Leave detailed message?: ☐Yes ☐No	Leave detailed message?: ☐Yes ☐No	Leave detailed message?: ☐Yes ☐No

Employer	Employer Address	City	State	Zip Code

Primary Care Provider:	**Referring Physician:**	**Ophthalmologist:**

Primary Insurance Coverage Name	Insurance ID #: ______________ Group #: ____________	Effective Date: ___________
Subscriber: ☐Patient ☐Spouse ☐Parent ☐Other Subscriber Name:	Date of Birth: ______________ Social Security #: ____________	Employer:

Secondary Insurance Coverage Name	Insurance ID #: ______________ Group #: ____________	Effective Date: ___________ Copay $: _______ Deductible: ______
Subscriber: ☐Patient ☐Spouse ☐Parent ☐Other Subscriber Name:	Date of Birth: ______________ Social Security #: ______________	Employer:

Emergency Contact	Relationship to Patient: ☐ Wife ☐Husband ☐Child ☐Parent ☐Friend ☐Guardian ☐Other
	Name: Contact Phone: Work Phone:

I hereby authorize direct payment to medical/surgical benefits to Prime Healthcare, PC for services rendered by our providers. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me above is correct. I hereby authorize Prime Healthcare, PC, its agents and representatives, to access information regarding my person, whereabouts, and to release all necessary information to my insurance company regarding my medical history, examinations, and treatments for the purposes of processing my insurance claims. A photocopy of my signature is valid as the original.

Signature: ______________________________________ Date: ____________________

PARENT / GUARDIAN INFORMATION

Relationship to Patient: ☐Parent ☐Guardian ☐Brother/Sister ☐Power of Attorney ☐Other

Name:	Social Security #:	Date of Birth:	Contact #:

PHARMACY NAME/ADDRESS:	**Phone Number:**