Patient Demographic Form

Please PRINT

ABBOTT MEDICAL GROUP

MRN **Date**

PATIENT INFORMATION

Last Name **First Name** **Middle Initial** **Nickname/AKA**

Date of Birth **Social Security Number** **Gender** ❑ Male ❑ Female

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Life Partner ❑ Separated ❑ Widowed ❑ Other **Language** other than English

Race (Optional) ❑ Black – Non Hispanic ❑ American Indian/ Alaskan Native ❑ Hispanic ❑ Asian/Pacific Islander ❑ White – Non Hispanic ❑ Other

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Email Address **Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other

Employer **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician **Referring Physician**

How did you hear about us? ❑ Billboard ❑ Employer ❑ Family Member ❑ Friend ❑ Health Fair Event ❑ Insurance ❑ Magazine ❑ Mail ❑ News ❑ Physician ❑ Radio ❑ Television ❑ Website ❑ Yellow Pages ❑ Other

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ❑ Self (If self, skip to Emergency / Next of Kin) ❑ Spouse ❑ Parent ❑ Other

Last Name **First Name** **Middle Initial**

Date of Birth **Social Security Number**

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Employer **Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other

Employer Phone

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name **First Name** **Relationship to Patient**

Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

OTHER CONTACT INFORMATION – NOT LIVING WITH PATIENT

Last Name **First Name** **Relationship to Patient**

Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

- **If copies of insurance cards are not attached, please complete Patient Insurance Form**

FIRST (PRIMARY) INSURANCE INFORMATION

Copy of card attached ❑ Yes (If yes, go to second insurance) ❑ No (Please provide reason)

Carrier Name **Insured's Name (as printed on card)** **Insured's Employer Name**

Relationship to Patient ❑ Self ❑ Spouse ❑ Parent ❑ Other

Policy # **Group #** **Effective Date**

SECOND (SECONDARY) INSURANCE INFORMATION

Copy of card attached ❑ Yes (If yes, go to third insurance) ❑ No (Please provide reason)

Carrier Name **Insured's Name (as printed on card)** **Insured's Employer Name**

Relationship to Patient ❑ Self ❑ Spouse ❑ Parent ❑ Other

Policy # **Group #** **Effective Date**

THIRD (TERTIARY) INSURANCE INFORMATION

Copy of card attached ❑ Yes (If yes, go to third insurance) ❑ No (Please provide reason)

Carrier Name **Insured's Name (as printed on card)** **Insured's Employer Name**

Relationship to Patient ❑ Self ❑ Spouse ❑ Parent ❑ Other

Policy # **Group #** **Effective Date**

OTHER INSURANCE INFORMATION

Injury(ies) due to accident ❑ At Work (Worker's Compensation Claim) ❑ Automobile Accident ❑ At Home ❑ Other

Accident City **Accident State** **Date of Injury**

Billing Name **Billing Address**

Claim Number **Effective Date**

Contact Person **Contact Telephone Number**

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf directly to Abbott Medical Group, PLLC. or its subsidiaries for any services furnished to me. I understand it is mandatory to notify the healthcare provider or any other party who may be responsible for paying for my treatment. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to be release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company or a related Medigap claim. I permit a copy of this authorization to be used in place of the original.

Signature **Date**

If your insurance is an HMO or managed care plan, you must obtain a referral from your Primary Care Physician (PCP). As a member of managed care plan, I understand I have an obligation to have all medical care coordinated by my PCP. I understand that I will be personally responsible for payment of services received if denied by my insurance carrier or if I do not have a referral from my PCP for any service dates.

Signature **Date**

OFFICE USE ONLY

Pre Authorization Required ❑ Yes (If Yes, plese print Insurance Authorization Number below) ❑ No

Verified By **Date Verified**