



**PATIENT DEMOGRAPHIC SHEET**

Please print and complete all information

DATE \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Birth date: \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status \_\_\_\_\_ Race \_\_\_\_\_

Address \_\_\_\_\_ E-Mail \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

I AGREE TO BE CONTACTED AT THE NUMBERS ABOVE FOR EMERGENCY REASONS INCLUDING THE POSSIBILITY OF MOVING OR CONFIRMING MY APPOINTMENT(S). \_\_\_\_\_ Initials \_\_\_\_\_

EMPLOYER \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

INSURANCE COMPANY NAME \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_ Group Number \_\_\_\_\_ I.D./Policy# \_\_\_\_\_

My Co-Payment per office visit is \_\_\_\_\_ Patient Signature \_\_\_\_\_

SECONDARY INSURANCE COMPANY NAME \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_ Group Number \_\_\_\_\_ I.D./Policy# \_\_\_\_\_

My Co-Payment per office visit is \_\_\_\_\_ Patient Signature \_\_\_\_\_

**AUTHORIZATION:**

I understand that I am financially responsible for all charges, whether or not covered by my insurance company. Payment is due at time service is rendered unless insurance is being billed. I permit payment directly to Decatur Vein Clinic for any benefits due for services rendered.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

