

PATIENT DEMOGRAPHICS – PLEASE PRINT

PATIENT NAME: _____ SSN _____ - _____ - _____ DOB: ____/____/____ SEX: M F MARITAL STAT.: M S D W

HOME ADDRESS _____ HOME PHONE #: (____)____ - _____
Street City State Zip

EMPLOYER/SCHOOL: _____ PHONE #: (____)____ - _____ ADDRESS: _____
Street City State Zip

EMERGENCY CONTACT: _____ RELATIONSHIP _____ PHONE #: (____)____ - _____

PRI. CARE PHYSICIAN: _____ PHONE #: (____)____ - _____ ADDRESS: _____
Street City State Zip

E-MAIL ADDRESS: _____

RESPONSIBLE PARTY

FATHER (if minor) OR SPOUSE NAME: _____ DOB ____/____/____

MOTHER (if minor) OR SPOUSE NAME: _____ DOB ____/____/____

ADDRESS: _____
Street City State Zip

ADDRESS: _____
Street City State Zip

PHONE #: (____)____ - _____ SSN _____ - _____ - _____

PHONE #: (____)____ - _____ SSN _____ - _____ - _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS: _____
Street City State Zip

EMPLOYER'S ADDRESS: _____
Street City State Zip

WORK PHONE#: (____)____ - _____ EXT: _____

WORK PHONE#: (____)____ - _____ EXT: _____

RESPONSIBLE PARTY INSURANCE

SUBSCRIBER NAME: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DOB: ____/____/____ RELATION TO PATIENT: _____

SUBSCRIBER DOB: ____/____/____ RELATION TO PATIENT: _____

PRIME INS CO.: _____

PRIME INS CO.: _____

INS. PHONE: (____)____ - _____

INS. PHONE: (____)____ - _____

ADDRESS: _____
Street or P.O Box City State Zip

ADDRESS: _____
Street or P.O Box City State Zip

POLICY or ID#: _____ GRP# _____

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I hereby authorize SMGOA to furnish information to my insurance carrier concerning my illness and treatments. I hereby assign to the physician all payments form medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature of Responsible Party, Parent or Guardian

____/____/____
Date

Print Your Name: _____