PATIENT DEMOGRAPHIC SHEET

Last Name_____First_____M.I. ____

Street Address_____City_____State_____Zip_____

Home #_____Cell #_____

Age_____Birthdate_____Sex_____Social Security #_____

Driver's License # _____Marital Status_____

Employed: Yes___ No____ Occupation_____Full/Part Time/Student

Employer_____Address_____

City_____State_____ Zip_____Work #_____

Emergeny Contact:_____Address_____

City_____State_____Zip_____Phone# _____

Friend/Relative _____Address_____

City_____State_____Zip_____Phone#_____

Referred By_____Phone #_____Date of Injury_____

Describe Nature of Illness/Injury_____

INSURANCE INFORMATION

1. Primary Insurance Carrier_____Name of Insured_____

Address_____Group#_____Certificate#_____Phone#_____

2. Secondary Insurance Carrier_____Name of Insured_____

Address_____Group#_____Certificate#_____Phone#_____

OFFICE POLICY: THE CHARGES INCURRED FOR THE EXAM/ TREATMENT/SUPPLIES/X-RAYS ARE THE RESPONSIBILITY OF THE PATIENT. PAYMENT FOR THESE CHARGES WILL NOT BE CONTINGENT UPON ANY INSURANCE OR THIRD PARTY COVERAGE. WHEN THE SERVICE IS RENDERED, PAYMENT FOR THE SERVICE IS EXPCECTED UNLESS OTHER ARRANGEMENTS ARE MADE.

ASSIGNMENT OF BENEFITS: I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO CARLO MEDINA, M.D. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY CARRIER. I AUTHORIZE A PHOTOGRAPHIC COPY OF THIS SHEET TO BE CONSIDERED AS AN ORIGINAL. I FURTHER AUTHORIZE RELEASE OF MY MEDICAL RECORDS AS DEEMED NECESSARY BY DR. MEDINA'S OFFICE.

DATE _____**SIGNATURE**_____

Original