PATIENT DEMOGRAPHICS FORM

Today's Date ____/____/____

PATIENT INFORMATION (*Please Print*)

Name _____
Last First Middle

Address _____
Street City State Zip

Gender □ Female □ Male **Marital Status** □ Married □ Single **Birth Date** _ _ / _ _ / _ _ _ _ **SSN** _ _ _ - _ _ - _ _ _ _

Race □ 1. White □ 2. Black □ 3. Am Indian/Eskimo/Aleut □ 4. Hispanic □ 5. Asian/Pacific Islander □ 6. Other □ 7. No Response

Ethnicity □ 1. Hispanic/Latino □ 2. NOT Hispanic/Latino

Pref. Language □ 1. Hispanic/Latino □ 2. NOT Hispanic/Latino

Home Phone (____)_____**Cell Phone** (____)_____ Messages with Health Information may be left on: □**Home** □**Cell** □**Neither**

E- Mail Address _____

Nearest Friend or Relative: _____
Name How Related Phone - ☐Home ☐Cell

□Yes □No – Do you give our office permission to discuss your health information, including appointments, with this person?

Preferred Pharmacy _____
Pharmacy Name Location

Smoking Status □ Current, every day □ Current, some days □ Former □ Never

Person responsible for paying your bills (only if you are a minor or have a guardian)

Name: _____ SS # _____
Last First MI Relationship to Patient

Address _____
Street City State Zip

Home Phone (____)_____ Cell Phone (____)_____ Birth Date _ _ / _ _ / _ _ _ _

BILLING INFORMATION: Do you have health insurance? □Yes □No

Primary Insurance Carrier: _____ Insured's Birth Date: _ _ / _ _ / _ _ _ _
Name of Insured: _____ Insured's SSN: _ _ _ - _ _ - _ _ _ _
(the patient)

Secondary Insurance Carrier: _____ Insured's Birth Date: _ _ / _ _ / _ _ _ _
Name of Insured: _____ Insured's SSN: _ _ _ - _ _ - _ _ _ _
(the patient)

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I have had an opportunity to review the practice's (a) Financial Policies and (b) Notice of Privacy Practices. I understand that I also may request of copy of either of these notices.

Dr. Gardner is a participating provider for most major insurance plans. As a courtesy, we will contact your insurance company to verify insurance eligibility and benefits before your appointment. We will also file an insurance claim for covered services if Dr. Gardner is considered in-network with your plan. Please remember that your medical insurance is a contract between you and your insurer, and any questions regarding coverage should be directed to your insurer. It is your responsibility to know how your insurance policy works. If we file an insurance claim for you, and that claim is rejected due to incorrect information given to us, you will be responsible for the balance. The portion that your insurer designates as "patient responsibility" – co-pay, coinsurance, and any unmet deductible – will be collected at the time of service. You will be notified of any remaining balance after insurance by paper statement. It is your responsibility to notify us of any changes in contact information, e.g., telephone number and address.

We accept cash, checks, and all major credit cards. We will accept commercial or business credit cards with an additional $5 fee. A $25 fee will be assessed for checks returned by your bank. If a second statement goes unpaid for longer than 30 days, your account will be forwarded to a collection agency. A $25 or 50% collections fee, whichever is greater, will be added to the outstanding amount owed to us.

Signature of Patient or Responsible Party: _____ **Date** ____/____/____

Please present your insurance card(s) and your photo identification (driver's license) to the receptionist. The receptionist will scan them, and then return them to you promptly.