## Dwayne E. Rollins, M.D. P.C.

# Patient demographic form

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| |  |  | | --- | --- | | Today’s Date: | Primary Doctor: |  PATIENT INFORMATION  |  |  |  |  |  | | --- | --- | --- | --- | --- | | Patient’s last name: | First: | Middle: |  | Marital status: |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Is this your legal name? | If not, what is your legal name? | Former name: | Birth date: | Age: | Sex: | |  |  |  |  |  |  |   Address:   |  |  |  | | --- | --- | --- | | Social Security no.: | Home phone no.: | Cell phone no.: | |  |  |  | | Occupation: | Employer: | Employer phone no.: | |  |  |  |  |  |  | | --- | --- | | Referring Physician: | Primary Care Physician: | | How did you hear about us? |   Would you like your results sent to your family doctor? **Y/N** (circle one) **Pharmacy Information**: INSURANCE INFORMATION(Please give your insurance card to the receptionist.)  |  |  |  |  | | --- | --- | --- | --- | | Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: | |  |  |  |  | | Is this person a patient here? |  | Is this patient covered by insurance? |  | | Occupation: | Employer: | Employer address: | Employer phone no.: | |  |  |  |  |   Please indicate primary insurance: |:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment: | |  |  |  |  |  | $ |   Patient’s relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]   |  |  |  |  | | --- | --- | --- | --- | | Name of secondary insurance (if applicable): | Subscriber’s name: | Group no.: | Policy no.: | | [Secondary Insurance] |  |  |  |   Patient’s relationship to subscriber: | IN CASE OF EMERGENCY  |  |  |  |  | | --- | --- | --- | --- | | Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: | |  |  |  |  |   I certify that the information given by me in applying for payment under Title XV11 of the Social Security Act is correct.  I authorize my physician to release to the Social Security Administration or its Intermediaries or carriers any information  Needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my  Behalf. I assign the benefits payable for physician services to my physician on claims for which they have accepted  Assignment and I authorize the physician to submit a claim to Medicare for payment on my behalf. I request that payment  under the insurance program be made to my physician on any bills for services furnished me by my physician for which  They have accepted assignment. I further release my physician to release medical information concerning my treatments to my insurance carrier (s)   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  | |  | Patient/Guardian signature |  | Date |  | |