## 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.)

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| --- | --- | --- | --- |
| 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 informationNeeded for this or a related Medicare claim. I request that payment of authorized benefits be made on myBehalf. 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)

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| --- | --- | --- | --- | --- |
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|  | Patient/Guardian signature |  | Date |  |

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