Advanced Neuropathy Clinic
469-814-9787

Patient Demographics Form

Name (Last, First, Middle) _____ Date of Birth: _____ Sex:__M, __F

Social Security #:_____ Phone #:_____ Cell #:_____

Address: _____ City, State, Zip: _____

Email Address: _____ Marital Status: _____ Language: _____

Primary Care Physician: _____ Referring Physician: _____

Employer: _____ Work #:_____

Primary Insurance: _____ Insurance Phone #:_____

Insurance Address: _____ City, State, Zip: _____

Policy #:_____Group #:_____

Name of Insured: _____ Date of Birth: _____

Relationship to Patient:_____

Secondary Insurance: _____ Insurance Phone #:_____

Insurance Address: _____ City, State, Zip: _____

Policy #:_____Group #:_____

Name of Insured: _____ Date of Birth: _____

Relationship to Patient:_____

Please Circle one below:

Asian Black/African American Hispanic Native American/Alaskan Native Pacific Islander/Native Hawaiian White

Do you have an Advance Directive? Y N If yes, please supply the office with a copy for your medical record.

May we send your medical records to other physicians? Y N If yes, which physicians you like us to send them to:

_____

I assign all medical and/or surgical benefits to which I am entitled, under private insurance, or any other health plan to Advanced Nueropathy Clinic. I authorize the release of my medical information necessary to process claims and direct payments of benefits from my insurance company, I accept financial responsibility for all charges, including but not limited to, copayments and annual deductibles.

_____ _____

Signature of Patient/Guardian/ Power of Attorney Date