SOUNDHEALTH FARMINGTON

Patient Demographic Information Form

Patient Last Name: _____ **First Name:** _____ **MI:** _____

Marital Status: SINGLE MARRIED DIVORCED WIDOWED **Social Security #:** _____ **Sex:** _____

Language: ENGLISH SPANISH OTHER: _____ _____ **Date of Birth:** _____

Ethnicity: HISPANIC OR LATINO NON-HISPANIC OR LATINO OTHER : _____

Race: AFRICAN AMERICAN BOSNIAN CAUCASIAN HISPANIC OTHER : _____

Emergency Contact Name: _____ **ER Contact Phone#:** _____

Patient Home#: _____ **Work#:** _____ **Cell#:** _____

Preferred Phone: HOME WORK CELL **Is it okay to leave a message?** YES NO

Email Address: _____ **Pharmacy:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employer: _____ **Occupation:** _____

Primary Care Doctor: _____ **Referring Doctor**(if different) _____

How did you hear about us? RADIO MAILER FACEBOOK PATIENT TV OTHER: _____

INSURANCE INFORMATION

Primary Insurance: _____ **Claims Address:** _____

Insured ID#: _____ **Group#:** _____ **Copay:** _____

Subscriber's Name (*if different than above*): _____

Subscriber's Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone#: _____ **Cell#:** _____ **Work#:** _____

Subscriber's DATE OF BIRTH: _____ **Subscribers SS#:** _____ **Sex:** _____

SECONDARY INSURANCE (Just leave blank if you do not have secondary insurance)

Secondary Insurance: _____ **Claims Address:** _____

Insured ID#: _____ **Group#:** _____

Subscriber's Name (if different than above): _____

Subscriber's Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell#:** _____ **Work#:** _____

Subscriber's DATE OF BIRTH: _____ **Subscribers SS#:** _____ **Sex:** _____

RESPONSIBLE PARTY INFORMATION (person bringing child to appointment)

Last Name: _____ **First Name:** _____ **MI:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell#:** _____ **Work#:** _____

Date of Birth: _____ **SS#:** _____ **Relationship to patient:** _____ **Sex:** _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes of the above information. I authorize the release of medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account is paid in full. I have received Sound Health Services, P.C. notice of privacy practices.

Responsible Party/Patient Signature: _____ **Date:** _____

*form updated for Gateway ENT 9-24-2018