THE REMEDY
A BETTER WAY FORWARD

Demographic Form

PATIENT INFORMATION:

Patient Name (Last, First, MI)_____
Gender: F( ) M( ) Other( ) **Preferred Pronouns**:( ) He, Him, His ( ) She, Her, Hers ( ) They, Them, Theirs

Date of Birth:____/___/_____ **Social Security Number**:____-____-_____
Marital Status: ( ) Single ( ) Married ( ) Divorced ( )Widowed ( )Cohabitating

Mailing Address:_____ **City**_____ **State**_____ **Zip**_____
Home Phone:_____-_____-_____ **Mobile Phone**:_____-_____-_____ **Work Phone**:____-_____-_____
E-mail:_____

Primary Care Doctor:_____**Phone**:_____**Fax**:_____
What is the best way to contact you? ( )Home ( )Cell ( )Email ( )Work **Can we leave a message?** ( ) Yes ( )No
Your Employer:_____ Occupation_____

How did you hear about us? ( )Internet Search ( ) Website ( ) Referral_____ ( ) Friend _____
( ) Other_____

Emergency Contact:_____ (**Name – Last,First**)_____
Phone:_____ **Relationship to Patient**: _____

Guarantor:(**Name – Last, First**)_____, _____ Relationship to Patient_____
DOB:___/___/_____ **SSN**:____-____-_____ **Home P**:____-____-_____ **Mobile**:____-____-_____

PRIMARY INSURANCE:_____ **SECONDARY**:_____
Individual Ins #:_____**Grp**:_____

To the best of my knowledge, all of this information is true and complete. I understand that I am responsible to pay for all services rendered to me. I am willing to make specific arrangements to pay any part not covered by insurance on a timely basis. A photocopy of this assignment is to be considered as valid as the original. If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made directly to the practice, for any service provided me by the practice's providers.

RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS: The Remedy may disclose all or part of the patient's medical or Financial Records to any person or corporation which may be liable under a contract to the clinic, including, but not limited to the patient, Insurance Carriers, or Welfare Funds. In the event the patient is entitled to clinic benefits of any type arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to the clinic for application to the patient's bill. The undersigned also gives the clinic and/or their representative permission to initiate a claim, on behalf of the patient, to any entity, person, or business that may be responsible for payment of services rendered.

Patient Signature:_____ **Date**:_____

Signature of Parent/Guardian:_____**Date**:_____