Demographics Verification Form

DEMOGRAPHIC INFORMATION			
Patient Name:			
Mailing Address:	City:	State:	Zip Code:
Home Phone:			
Cell Phone:			
Work Phone:			
Date of Birth:	Sex:	Marital Status:	
Social Security Number:			
Employer Name:			
Employer Address:			
Primary Care Provider:			
Email:			
Select One: White ____ Black ____ Hispanic ____ Other: ______________		Language spoken:	
OK to Leave Message: □ **Home** □ **Cell**	□ **Brief** □ **Extended**		
EMERGENCY CONTACT INFORMATION			
Emergency Contact Name:			
Phone Number:			
Relationship to Patient:	□**HIPAA**		
GUARANTOR/RESPONSIBLE PARTY			
Name:			
Guarantor Address:			
Guarantor Date of Birth:			
PRIMARY INSURANCE INFORMATION			
Insurance:			
Insured's Name:	Insured's Date of Birth:		
Subscriber Number:			
Subscriber Address:			
Group Number:			
Insured's Rel to Pt:			
SECONDARY INSURANCE INFORMATION			
Insurance:			
Insured's Name:	Insured's Date of Birth:		
Subscriber Number:			
Subscriber Address:			
Group Number:			
Insured's Rel To Pt:			
PHARMACY INFORMATION			
Pharmacy Name/Location:			
Pharmacy Number:			
Alternate Pharmacy Name/Location/Phone:			

I attest that the above information is correct and have read and understand the policies of Eagles Landing Family Practice, and accept my responsibility as stated in those policies. I hereby authorize release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge.
I hereby allow the clinical staff of Eagles Landing Family Practice to view my medication history from external sources.

_______________________________________ **DATE** ____________________

Patient Signature (17 and under requires signature of Parent/Guardian)

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Relationship To Child