EAGLES LANDING FAMILY PRACTICE
Providing care at your convenience

Demographics Verification Form

DEMOGRAPHIC INFORMATION			
Patient Name:		Preferred Name:	
Mailing Address:			
City:	State:	Zip:	County:
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/African Amer____ 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)

_____

Relationship To Child