DEMOGRAPHIC INFORMATION SHEET

MEMORIAL MEDICAL GROUP, LLC

PATIENT INFORMATION

First Name: _____ MI: _____
Last Name: _____
Maiden Name: _____
Sex (Please Circle): M F Age: _____
Birth Date: (MM/DD/YYYY): _____
Marital Status: □ Single □ Married
□ Divorced □ Widowed
SSN#: _____
Race: □ White □ Black/African American
□ American Indian/Native Alaskan □ Asian
□ Hawaiian/Pacific Islander □ Two or more races
Preferred Language: _____
Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino
Is patient FULL TIME STUDENT? □ Yes □ No

ADDRESS

Street: _____
PO Box / Apt # : _____
City/State/Zip: _____
E-Mail: _____
Home #: _____
Work #: _____
Cell #: _____
Minors: Lives with □ Mother □ Father □ Both

MAILING ADDRESS (if different from above)

Street: _____
PO Box / Apt # : _____
City/State/Zip: _____

PATIENT or LEGAL GUARDIAN EMPLOYER

Employer Name: _____
Street: _____
PO Box / Suite # : _____
City/State/Zip: _____
Occupation: _____

(If applicable): PARENT / LEGAL GUARDIAN

First Name: _____ MI: _____
Last Name: _____
Relationship to Patient: _____
Home #: _____
Work #: _____
Cell #: _____

EMERGENCY CONTACT (OTHER THAN ABOVE)

First Name: _____ MI: _____
Last Name: _____
Relationship to Patient: _____
Home #: _____
Work #: _____
Cell #: _____

INSURANCE INFORMATION

(PLEASE PRESENT ALL CARDS SO THAT THEY MAY BE COPIED AND SAVED WITH YOUR RECORDS)

Primary Insurance Carrier

Insurance Carrier: _____
Insured Name: _____
Insured DOB (MM/DD/YYYY): _____
Insured SSN #: _____

Secondary Insurance Carrier

Insurance Carrier: _____
Insured Name: _____
Insured DOB (MM/DD/YYYY): _____
Insured SSN #: _____

Other Insurance Coverage

Is this visit for a Workers Compensation issue?
□ Yes □ No
Is this visit for an Auto Insurance issue?
□ Yes □ No

PHYSICIAN INFORMATION

Referring Physician: _____
Phone #: _____
Family Physician: _____
Phone #: _____

I hereby assign directly to Memorial Medical Group, LLC, or any of its subsidiaries, all medical benefits, if any, otherwise payable to me for services rendered. I understand that all services rendered to me (or my dependents) are charged directly to me and I am personally responsible for payment of all charges whether or not paid by insurance. The patient or their responsible legal guardian agrees to pay any and all costs of collection and/or attorney fees required to settle account balance. I authorize the release of all information necessary to my current or valid insurance carrier in order to secure the payment of benefits for services rendered .

_____
Patient Signature & Date

_____
Legal Guardians Signature & Date

_____
Relation to Patient