**HARTH PLACE FAMILY MEDICINE**
**PATIENT DEMOGRAPHIC FORM**

PATIENT NAME:___________________________ PATIENT DATE OF BIRTH:__________
SSN:_____________________ SEX:___ MARITAL STATUS:_______
STREET ADDRESS:____________________________________ LOT/APT #_________________
CITY/STATE/ZIP:__________________________________________________________________
HOME PHONE:_____________________ WORK:__________________ CELL:_______________
PATIENT EMPLOYER NAME:_______________________________________________________
EMAIL___________________________________ PHARMACY____________________________

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PRIMARY INS COMPANY:__________________________________________________________
INS ADDRESS:_________________________________________________________________
INSURED'S NAME:_________________________________ RELATIONSHIP TO PT:__________
DATE OF BIRTH:____________________ EMPLOYER:__________________________________
ID/POLICY #:__________________________ GROUP#________________

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SECONDRAY INS COMPANY:________________________________________________________
INS ADDRESS:_________________________________________________________________
INSURED'S NAME:________________________________ RELATIONSHIP TO PT:__________
DATE OF BIRTH:_____________________ EMPLOYER:_________________________________
ID/POLICY #:____________________________ GROUP#_________________

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TERTIARY INS COMPANY:_________________________________________________________
INS ADDRESS:_________________________________________________________________
INSURED'S NAME:________________________________ RELATIONSHIP TO PT:___________
ID/POLICY #:_____________________________ GROUP#:__________________

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EMERGENCY CONTACT NAME:________________________ PHONE #:___________________

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I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY CLAIMS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS AND/OR GOVERNMENT BENEFITS TO HARTH PLACE FAMILY MEDICINE. I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY THE INURANCE COMPANY.

PATIENT SIGNATURE:_____________________________________________ DATE:_____________________

PARENT OR LEGAL GUARDIAN SIGNATURE (IF MINOR):_________________________________________ DATE:_____________