Between the Bridges Healing Center

PATIENT DEMOGRAPHIC FORM

Today's Date_____

PATIENT INFORMATION

Patient Name: _____ Social Security No.: _____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Sex: M F Marital Status: Single Married Widow/er Divorced Partner

Mailing Address: _____
Street Apt. No. City State Zip

Physical Address (if not same as mailing): _____
Street City State Zip

Home Phone: (_____) _____ - _____ OK to leave a msg? Y__N__ Cell: (_____) _____ - _____ OK to leave a msg? Y__N__

E-Mail Address: _____ (Required for patient portal access and appointment reminders)

Emergency Contact Name: _____ Phone: (_____) _____ - _____ Relationship: _____

Address: _____ OK to discuss medical information? Y__ N__

Emergency Contact Name: _____ Phone: (_____) _____ - _____ Relationship: _____

Address: _____ OK to discuss medical information? Y__ N__

Employer: _____Occupation:_____

Address: _____ Work Phone: (_____) _____ - _____

GUARANTOR/PARENT INFORMATION

Responsible Party Name: _____ DOB: _____/_____/_____ Social Security No.: _____/_____/_____

Address: _____ Home Phone: (_____) _____ - _____

Employer: _____ Work Phone: (_____) _____ - _____

Relationship to Patient: _____ Cell/Pager No.: (_____) _____ - _____

PATIENT'S INSURANCE INFORMATION

Do You Currently Have Medicare Coverage? Yes No

If yes, please provide your Medicare ID number:_____

Please note, Medicare requires that we establish a contract directly with all patients who have Medicare coverage in order to disclose all relevant information regarding our Opt Out Status. You will be presented with this contract at the time of your first appointment.

How did you hear about us?

- Referral by a Dr? Please provide Dr's name: _____
- Referred by a friend? Please provide the name of our friend: _____
- Attended a presentation by Dr. Kunkel?
- Attended a presentation by Dr. Kotulski?

(Please Read and Sign)

I understand that I am responsible for all charges incurred on my behalf, including any added costs incurred due to any effort to collect for services rendered.

Responsible Party: _____ Date: _____