Optimal Health Associates

Patient Demographic Form

Please print neatly and fill in all blanks

Patient's Legal Name: _____
(first) (middle) (last)

Date of Birth:_____/_____/_____ Age:_____ Social Security No._____-_____-_____

Circle One: Single Married Divorced Separated Other:_____

Patient's Address:_____
(street address) (city) (state) (zip code)

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Employer:_____ Email Address:_____

Primary Care Physician:_____ Phone Number:_____

Referring Physician:_____ Phone Number:_____

Name of the Primary Insurance Company: _____

Name of person who carries insurance:_____ Relationship to Patient:_____

Carriers DOB:_____/_____/_____ Carriers SSN:_____/_____/_____Carriers Employer:_____

Secondary Insurance Company (if applicable) _____

Name of person who carries Insurance:_____Relationship to Patient:_____

Carriers DOB_____/_____/_____Carriers SSN:_____/_____/_____Carriers Employer:_____

Spouse's Name:_____ Phone:_____

Nearest relative not living with you:_____ Relationship:_____ PH:_____

If patient's a minor, please list both parents information:

Mother:_____ Employer:_____Ph:_____

Father:_____ Employer:_____PH:_____

I hereby authorize my insurance benefits to be paid directly to the facility and the physician. I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge and agree and received a copy of the HIPPA Privacy Notices.

_____

Signature Date