## *Suburban Surgical Associates, Ltd. /Suburban Metabolic Institute, LLC*

# PATIENT DEMOGRAPHICS

**WELCOME TO OUR PRACTICE** **Today's Date:**

## *Demographics*

*Patient Name:*______________________________________________________*Cell#*__________________ *Home#*_________________

*Last name:* *First Name:* *Middle Initial*

*Address:*__________________________________*City:*________________________*State:*_______*Zip Code:*____________

*Date of Birth:*__________ *Race:*__________ ❒ *Hispanic* ❒ *Non-Hispanic* *Ethnicity:*___________ *Language:*____________

*Social Security/ITIN#:* ______________________________________*Email:*__________________________________________________

*Marital Status:* ❑ *Single* ❑ *Married* ❑ *Separated* ❑ *Divorced* ❑ *Widowed* *Gender:* ❑ *Male* ❑ *Female*

*Are you employed?* ❑ *Yes* ❑ *No* ❑ *Disabled* ❑ *Retired* *Email Address:*_______________________________________

*Employer Name:*___________________________________*Work Phone:*_________________*Occupation:*______________________

*Employer Address:*___________________________________*City:*___________________*State:*__________*Zip*_________

*Emergency Contact:*___________________________________*Home Phone:*___________________*Work/Cell#*__________________

*Relationship:* ❑ *Spouse* ❑ *Parent* ❑ *Siblings* ❑ *Son/Daughter* ❑ *Friend* ❑ *Other*______________________

*Parent/Guardian Name:*_______________________________________________*Phone#*____________________________

*Pharmacy Name:*_______________________________ *Pharmacy Phone #*___________________________________

## *PRIMARY INSURANCE*

*Name of Insurance:*________________________________________________*Phone Number:*____________________________

*Address:*_________________________________*City:*________________*State:*________*Zip Code:*_______________

*Group I.D. #*___________________ *Policy #*____________________*Type:* ❑ *HMO* ❑ *PPO* ❑ *OTHER*____________

*Relationship to Policy Holder:* ❑ *Self* ❑ *Spouse* ❑ *Dependent Child*

*Policy Holder's Name:*_______________________*Policy Holder Date of Birth*_______________*Social Security #*________________

## *SECONDARY INSURANCE*

*Name of Insurance:*________________________________________________*Phone Number:*____________________________

*Address:*_________________________________*City:*________________*State:*________*Zip Code:*_______________

*Group I.D. #*___________________ *Policy #*____________________*Type:* ❑ *HMO* ❑ *PPO* ❑ *OTHER*____________

*Relationship to Policy Holder:* ❑ *Self* ❑ *Spouse* ❑ *Dependent Child*

*Policy Holder's Name:*__________________________*Policy Holder Date of Birth*_______________*Social Security #*______________

**Primary Care/Ref. Physician:**__________________________________________**Phone Number:**___________________________

**Address:**________________________________**City:**_________________**State:**______________**Zip Code**________

**Insurance Authorization and Assignment:**

I authorize the release to Medicare/Other Insurance Company of such information as may be necessary for the completion of my insurance claims. I hereby authorize payment directly to ***Suburban Surgical Associates, Ltd./ Suburban Metabolic Institute, LLC*** of the expense benefits otherwise payable to me. If item 9 of the CMS-1500 claim form is completed, my signature authorizes releasing of the information and payment to the insurer or agency known. I understand that I am financially responsible for the charges made by them for services rendered. I have read this document in it's entirely and I fully understand it.

**Signature:**_____________________________________________________________ **Date**:_________________________________