McKinney Adult Medicine *Patient Demographics*

Phone Numbers: #1 _____ #2 _____ #3 _____
H-HOME, **W**-WORK, **C**-CELL **H**-HOME, **W**-WORK, **C**-CELL **H**-HOME, **W**-WORK, **C**-CELL

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other _____

Name _____ DOB _____ SSN _____

Address _____ City _____ State ____ Zip _____

Marital Status: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____ Sex: Female _____ Male ____

Employment Status: Employed _____ Unemployed _____ Self Employed _____ Retired _____ F/T Student _____ P/T Student _____

Employer _____ Occupation _____

Whom may we thank for referring you? _____ _____

In case of an emergency who should be notified? _____ Phone # _____

Primary Insurance Information

Insured Party_____ DOB _____ SSN _____

Relationship to Patient _____ Employer _____

Insurance Company _____ Address _____

Member ID # _____ Group # _____ Phone # _____

Effective Date _____ Termination Date _____ Co-Pay _____

Secondary Insurance Information

Insured Party_____ DOB _____ SSN _____

Relationship to Patient _____ Employer _____

Insurance Company _____ Address _____

Member ID # _____ Group # _____ Phone # _____

Effective Date _____ Termination Date _____ Co-Pay _____

Assignment of Benefits and Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made to **McKinney Adult Medicine** and any assisting physicians, for the services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date _____ Signature _____