



PATIENT DEMOGRAPHICS FORM

FIRST NAME: MI:

LAST NAME: Nickname:

ADDRESS:

CITY, STATE, ZIP:

HOME PHONE:

WORK PHONE: CELL:

EMPLOYER: PHONE:

I WOULD LIKE DR. BARRETT TO CALL ME AT: home work other

SOCIAL SECURITY NUMBER:

DATE OF BIRTH:

MALE OR FEMALE? SINGLE OR MARRIED?

INSURANCE COMPANY:

NAME OF INSURED: SSN:

RELATIONSHIP TO INSURED:

ID#: GRP#:

Ins Contact & Phone #:

EMERGENCY CONTACT:

NAME, ADDRESS, PHONE

REFERRING PHYSICIAN:

PCP (Primary care doctor):

PATIENT IS RESPONSIBLE FOR OBTAINING ALL REFERRALS & Ins. AUTHORIZATIONS

- Regardless of insurance, I acknowledge that I am ultimately responsible for payment of services provided by Dr. Barrett. I agree to pay all fees not covered and/or denied by my insurance company.
- I hereby authorize assignment of benefits to be paid directly to Dr. Barrett.
- I authorize Dr. Barrett to provide protected health information to my insurance company for billing purposes.
- I acknowledge review of HIPPA notice, and have received a copy if I requested it.

PATIENT SIGNATURE

DATE