# PATIENT DEMOGRAPHIC INFORMATION

**Patient's Name:** ____________________________________ **Date of Birth:** _______________

**Address:** _______________________________________________________________________
Street City State Zip

**Phone: Home**________________ **Work**___________________ **Cell**________________________

**Email:** _____________________________

**Pharmacy: Name**__________________ **Address**______________________ **Phone** ___________

**Sex: [ ] Male [ ] Female Race** __________ **Social Security:** __________________________
**Ethnicity [ ] Hispanic [ ] Non-Hispanic** **Preferred Language:** __________________
**Marital Status: [ ] Married [ ] Single [ ] Widowed** **Spouse's Name:**_____________________
**Referring Physician** __________________ **Primary Care Physician:**_____________________
**How Did You First Hear About Us?** ________________________________________________

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**Responsible Party (if other than patient):** ______________________________________________
**Relationship to Patient:** _____________________
**Address:** _______________________________________________________ **Phone:**___________
Street City State Zip

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**In Case of Emergency, Who Should We Contact?**

**Name:** ______________________________________________ **Relationship:** ________________

**Phone:** ______________________________ **Alternate Phone:** ________________________

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**Primary Insurance:** ________________________________________________________________
**Insured's Name:** ____________________________ **Relationship to Patient:**______________
**Insured's SS#:** ______________________________ **Date of Birth:** ______________________
**Primary Policy #**____________________________ **Group#**____________________________
**Employer name and phone#**_________________________________________________________

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**Secondary Insurance:** ______________________________________________________________
**Insured's Name:** ___________________________ **Relationship to Patient:**______________
**Insured's SS#:** ______________________________ **Date of Birth:** _____________________
**Secondary Policy#**___________________________ **Group#**_____________________________
**Employer name and phone#**_________________________________________________________

I authorize Desert Spine and Sports Physician (DSSP), to release any information necessary to my insurance carrier and/or their agents in order to determine benefits payable for related services. I authorize the payment of medical benefits for these services to be paid directly to DSSP. I authorize the release of all clinical information to my other health care providers so that he/she can be updated on my condition and the care I receive here.

**Patient's Signature:** _______________________________ **Date:** ________________