Patient demographic sheet:

Date of first appointment: _____/_____/_____ marital status: S M D W Sex: ☐Male ☐Female

Name: _____Birth date: _____/_____/_____ Age: _____

Address: _____ Social Security #:_____-_____-_____

City:_____ Zip Code: _____ Cell _____-_____-_____

Contact Information: Home _____-_____-_____ Email: _____

Emergency Contact: _____ Phone number: _____-_____-_____

PCP information:

Primary Care Physician: _____ Phone Number: _____-_____-_____

Address: _____ Fax Number: _____-_____-_____

Referral Information:

Referred here by: (Check one) ☐ Self ☐ Friend or Family ☐ Doctor

If referred by a doctors office please provide information:

Referring Doctor: _____Phone Number: ____-_____-_____

Address: _____ Fax number: ____-_____-_____

Pharmacy Information:

Preferred Pharmacy: _____ Phone Number: ____-_____-_____

Pharmacy Address: _____ Fax Number: ____-_____-_____

Insurance Information:

Primary Health Insurance: _____ Policy holders name: _____

Insurance ID Number: _____ Insurance Group Number: _____

Secondary Health Insurance: _____ Policy holders name: _____

Insurance ID number: _____ Insurance Group Number: _____

I request that payment of authorized benefits be made on my behalf directly to S'eclairer for any services provided. To that extent permitted by law, I authorize any holder of medical or other information about me to be release to my insurance carrier, and their agents to determine these benefits for related services. I permit a copy of this authorization to be used in place of the original.

Policy Holder Name: _____Policy Holder Birth Date:____/____/_____

Policy Holder Social Security #:_____-_____-_____

RELEASE AND ASSIGNEMNT:

- I authorize this form or a copy of it on used on all my insurance submissions.
- I authorize release of information to my insurance company for purposes of utilization and quality assurance reviews.
- I authorize the release of any information necessary to process my claim and assign payment requests to my provider.
- I authorize payment directly to S'eclairer, PC.
- I will endorse any checks payable to me that should have been directed to S'eclairer.
- I agree that payment for services provided remain my responsibility in the event my insurance does not reimburse for services.
- I have received a copy of the above named provider's privacy policy.

Patients Signature: _____ Date: ____/____/_____

S'eclairer, P.C. –HIPAA
Privacy Policy Notice Provided
Date:_____ Initials:_____