Thomas D. Bianchi, M.D., P.A. Patient Demographic Information Sheet

PATIENT'S NAME _____

DATE OF BIRTH _____ **AGE** _____ **MALE** _____ **FEMALE** _____ **RACE** _____

PHARMACY NAME _____

ETHNICITY Hispanic or Latino _____ Not Hispanic or Latino _____ Declined _____

SOCIAL SECURITY # _____ **DRIVER'S LICENSE #** _____

PATIENT MARIATAL STATUS S M W D **EMAIL ADDRESS** _____

PATIENT'S MAILING ADDRESS _____

PATIENT'S HOME ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

HOME PHONE # _____ **WORK #** _____ **CELL #**_____

PATIENT EMPLOYER _____

EMPLOYER'S ADDRESS _____**PHONE #**_____

CITY_____ **STATE** _____ **ZIP** _____

SPOUSE'S NAME _____ **DATE OF BIRTH** _____

SPOUSE'S EMPLOYER _____**PHONE #**_____

CITY _____ **STATE** _____**ZIP** _____

PRIMARY INSURANCE _____ **POLICY #**_____

SUBSCRIBER NAME _____**DATE OF BIRTH**_____**SSN**_____

SECONDARY INSURANCE _____ **POLICY #** _____

SUBSCRIBER NAME _____**DATE OF BIRTH**_____**SSN**_____

IN CASE OF AN EMERGENCY:

NAME _____**RELATIONSHIP**_____**PHONE #**_____

PRIMARY DOCTOR _____**Phone**_____

I AM AWARE OF MY RIGHTS TO PRIVACY OF MY MEDICAL RECORDS. I have access to the privacy policy of Dr. Thomas D. Bianchi. I give my consent to be treated by Dr. Bianchi for any condition for which I might seek treatment. I understand my insurance will be billed but might not pay all or any of my charges. Therefore, I am responsible for all balances not paid by my insurance. I also understand that my co-pay or deductible is due at the time of service. I hereby authorize Dr. Thomas D. Bianchi to furnish the insurance company with the necessary information to file any claim for my treatment. Also, I give permission to photocopy, fax, or transmit any information about my treatment by Dr. Bianchi to any insurance company, other physician, hospital or pharmacy. I give permission to send pertinent information to the credit bureau to collect my past due account if that becomes necessary. I understand that if my account goes unpaid after a reasonable length of time, additional charges may be applied to my account to cover collection fees and a reasonable attorney's fee. I authorize payment of benefits directly to the doctor's office that accepts assignment unless prior arrangements are stated and agreed upon. This agreement shall remain in effect until I give notice otherwise. I also understand that if I have no insurance the full amount of my bill is due at the time of service.

PATIENT SIGNATURE _____ **DATE** _____