Krystle Dandridge LLC

DEMOGRAPHIC FORM

Today's Date: [Date]	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle: [Choose an item]	Marital status: [Choose an item]

Is this your legal name?	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:
◯ Yes ◯ No			[Birthday]		◯ M ◯ F

Address: [Address/ P.O Box, City, ST ZIP Code]

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation: Not Needed	Employer: Not Needed	Employer phone no.: Not Needed

Referred By: ◯ ◯ [Choose an item]

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: [Birthday]	Address (if different):	Home phone no.:
Is this person a patient here?	◯ Yes ◯ No	Is this patient covered by insurance?	◯ Yes ◯ No
Occupation: NA	Employer: NA	Employer address: NA	Employer phone no.: NA

Please indicate primary insurance: Insurance 1 | Other:

Subscriber's name:	Subscriber's S.S. no.: NA	Birth date: [Birthday]	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: [Choose an item]

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: [Choose an item] | Other:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Krystle Dandridge LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature ______________________ Date ______________