Physician Name: Stephen De Young, M.D.

PATIENT DEMOGRAPHIC INFORMATION SHEET

Last Name | **First Name** | **Middle** | **Social Security No.**

Date of Birth | **Age** | **Male or Female** *(Please circle one)* | **Marital Status: M S W D** *(Please circle one)*

Home Address | **City** | **State** | **Zip**

Home Phone | **Work Phone** | **Cell Phone**

Contact Preference: *(Please Check One)* **Home** **Work** **Cell** **Mail** | **Email Address**

Referred By: | **Phone #:**

EMERGENCY CONTACT INFORMATION

Name | **Phone No.** | **Alt. Phone** | **Relationship**

PATIENT EMPLOYER INFORMATION

Employer Name | **Phone** | **Fax**

Address | **City** | **State** | **Zip**

GUARANTOR / POLICY HOLDER INFORMATION

Last Name | **First Name** | **Middle** | **Social Security No.**

Date of Birth | **Patient's Relationship to Policy Holder** | **Home Phone** | **Cell Phone**

Employer Name | **Phone** | **Fax**

Employer Address | **City** | **State** | **Zip**

INSURANCE INFORMATION

Primary Insurance	**Name of Primary Insurance**	**ID/Policy Number**	**Group Number**	**Customer Service No.**
Secondary Insurance	**Name of Secondary Insurance**	**ID/Policy Number**	**Group Number**	**Customer Service No.**
Work Comp Insurance	**Name of WC Insurance**	**Claim #**	**Adjuster Name**	**Adjuster Phone No.**

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF ALL CHARGES WITHIN 50 DAYS. **AUTHORIZATION TO RELEASE INFORMATION:** I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OF TREATMENT.

Signature: | **Date:**