PATIENT DEMOGRAPHICS

Patient Name _____
LAST FIRST MIDDLE

Date of Birth _____ Social Security Number _____

Address _____ Apt _____

City/State/Zip Code _____

Telephone: Home _____ Cell _____ Work _____

Email address _____

Check One: ____ Single ____ Married ____ Other

Referred by _____

Employer_____

Employer Address _____

Emergency Contact _____ Relationship_____

Address_____ Phone Number_____

**Insurance Information**

*Primary Insurance* _____

Address _____ City/State/Zip_____

Group Number _____ Policy/ID#_____

Guarantor Name _____ Guarantor DOB _____

*Secondary Insurance* _____

Address _____ City/State/Zip_____

Group Number _____ Policy/ID#_____

Guarantor Name _____ Guarantor DOB _____

**Assignment of Insurance Benefits and Authorization to Release Information**

I authorize payment of medical benefits to Quynh-Thu "Gigi" Doan, MD for any and all services not paid in full at the time those services are rendered. I authorize Quynh-Thu "Gigi" Doan, MD to release any medical information as necessary for the completion of my insurance claims to any insurance carrier, health, or hospital plan.

Patient Signature _____ Date_____

Patient's Legal Guardian/Agent_____ Date_____