Gastroenterology HEALTH PARTNERS

PATIENT DEMOGRAPHIC FORM

How did you hear about us? ☐ MD Referral ☐ Internet Search ☐ GHP Website ☐ Print Ad ☐ Other ____________________

Last Name:_____________________ Maiden Name__________________ First Name:____________________ Middle:_______

Address:_________________________________ City:__________________ State:_____ Zip:________

Home Phone: ( )__________________ Cell Phone: ( )________________________ Email: _________________________

SS#:_____________-__________-____________ ☐ Male ☐ Female Date of Birth: _______/_______/________

Race: ________________________ Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other/Undetermined

Occupation:____ Employer:____

Address:____ City:___________________ State:_____ Zip:______________

Primary Care Physician:____________________________________

Pharmacy:_______________________ Address:____ Phone:______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

Emergency Contact:____ Relationship: ________________________________

Phone: ( )__________________________________ ☐ Home ☐ Work ☐ Cell

RESPONSIBLE PARTY

☐ Self ☐ Spouse ☐ Other (complete below)

Full Name:____DOB:____/______/___

SS#_______-______-______ Relationship to Patient: ____

Address:____ City:______________________________ State:_____ Zip: ________

Home Phone: ( )_____________________ Work Phone: ( )________________________ Cell Phone: ( )_________________

Employer: ____

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INSURANCE

Primary Insurance:____ Policy Holder: _____________________________________

Date of Birth:________/_________/_______ Relationship: ____

Insurance ID Number:__________________________________Group Number: ____

Secondary Insurance:____ Policy Holder: ___________________________________

Date of Birth:________/_________/_______ Relationship: ____

Insurance ID Number:__________________________________ Group Number: _______________________________________

I attest that all information listed above is complete and correct. I acknowledge that I am financially responsible for all charges regardless of payments made by my insurance in accordance with the Gastroenterology Health Partners, PLLC Financial Policy.

Responsible Party Signature ____ Date ____________________

Relationship ____