

**PLAZA MEDICAL GROUP - PATIENT DEMOGRAPHIC FORM**

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
(First) (Middle) (Last)

Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone ( ) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male  Female

Marital Status: S  M  D  W  Social Security # \_\_\_\_\_ Nick Name \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
(Street) (City) (State) (Zip)

Cell Phone ( ) \_\_\_\_\_ Driver's License State and # \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse's SS# \_\_\_\_\_ Spouse's Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Emergency Contact (other than spouse) \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**BILLING INFORMATION (Person responsible for payment)**

Name \_\_\_\_\_ Phone \_\_\_\_\_  
(First) (Middle) (Last)

Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

**INSURANCE INFORMATION**

**Primary Health Plan - Cardholder's Insurance Information** Effective Date \_\_\_\_\_

Insurance Name \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_

Primary Care Provider \_\_\_\_\_ PCP Phone ( ) \_\_\_\_\_

If patient is insurance holder (subscriber) check here  and go to secondary plan, otherwise complete the following.

Subscriber Name \_\_\_\_\_ Relationship to Subscriber: Spouse  Child  Other \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone ( ) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male  Female  SS # \_\_\_\_\_

**Secondary Health Plan - Cardholder's Insurance Information** Effective Date \_\_\_\_\_

Insurance Name \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_

Primary Care Provider \_\_\_\_\_ PCP Phone ( ) \_\_\_\_\_

If patient is insurance holder (subscriber) check here , otherwise please complete the following.

Subscriber Name \_\_\_\_\_ Relationship to Subscriber: Spouse  Child  Other \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone ( ) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male  Female  SS # \_\_\_\_\_

**REFERRAL INFORMATION**

Doctor who referred you: \_\_\_\_\_ Phone (    ) \_\_\_\_\_

Address \_\_\_\_\_

**Other doctors involved in your care:**

Name \_\_\_\_\_

Name \_\_\_\_\_

City/State \_\_\_\_\_

City/State \_\_\_\_\_

Phone (    ) \_\_\_\_\_

Phone (    ) \_\_\_\_\_

**ATTENTION: IMPORTANT INFORMATION**

It is the patient's responsibility to know which laboratory is in their insurance's network. If the patient does not present us with the correct information as to what network their insurance uses, so we may send their lab to the correct lab at the time of service, **the patient will be responsible for any and all laboratory charges incurred in our office.**

My network lab is: \_\_\_\_\_

If there are any questions as to which labs are in your insurance network, you must call your insurance company to verify prior to having your blood drawn.

\_\_\_\_\_  
Patient's signature/if patient is under 18, guardian signature Date \_\_\_\_\_ 20\_\_\_\_

**ADVANCE DIRECTIVE FOR HEALTH CARE**

**Do you have an Advance Directive for Health Care (Living Will)?** Yes  No

**Are you aware that you have the right to have an Advance Directive for Health Care (Living Will)?** Yes  No

**AUTHORIZATIONS**

**Benefits to Physicians:** I hereby authorize payment of medical and/or hospital benefits directly to the physician by my insurance company or companies. I also understand that I am responsible for any portion of my bill not covered by my insurance company or companies.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Release of Information:** I hereby authorize Plaza Medical Group to release or disclose appropriate medical records to any insurance company or third party payor, **liable to the patient, for payment of claims.** I also authorize Plaza Medical Group to release or disclose any medical records to the patient's primary care physician, consulting physician(s), and other health care providers who have a legitimate need for such information in the care and treatment of the patient. I understand that anyone else needing the patient's records, must have a signed '**records release**' by the patient, (a form other than this one).

By state law, you must be advised that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, disease such as hepatitis, syphilis, gonorrhea and the disease known as AIDS. We have the Confidentiality Requirements of the State of Oklahoma Available for you to read, upon your request.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_