DEMOGRAPHIC INFORMATION FORM

First name	**Middle name**	**Last name**
Birthdate	**Social Security Number**	**Email address**
Street Address		
City	**State**	**Zip Code**
Home phone	**Cell phone**	
Primary care physician (PCP)	**PCP phone number**	
Emergency contact	**Phone number**	**Relationship**

Primary language	**Gender**	**Race/ Ethnicity**
Marital status	**Employer**	

Primary insurance	**Subscriber name**	
Subscriber birthdate	**Enrollee ID**	**Group number**

Secondary insurance	**Subscriber name**		
Subscriber birthdate	**Enrollee ID**	**Group number**	
Is it okay to leave a message on your voicemail or answering machine?			
Please list the names of anyone you would like Advanced Pain Solutions to share Personal Health Information with:	**Name:**	**Phone Number:**	**Relationship:**
	1.		
	2.		
	3.		

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 Advanced Pain Solutions or my insurance company to release any information required to process my claims.

Patient/ Guardian Signature: _____ Date: _____