PATIENT DEMOGRAPHICS

First Name:______________________________ Last name:____________________________________
MI:________
Preferred Name:_______________________________________ Preferred
Pronoun:____________________________

Mailing Address:____Apt.
#______________
(Include PO Box and Street Address if both apply)
City:_______________________________________ State:___________________ Zip
Code:_____________________
Main Phone #_______________________________ Cell Phone
#____
Date of Birth__________________ Birth Assigned Gender: Male__ Female__ Current Gender
Identity____________
Marital Status: S___M___W___D___P___Separated____ Spouse's
Name____________________________________
Race: Caucasian_____ African American_____ Bi-racial_____ Hispanic______
Other____________________________
Social Security Number_________________________ Employed____ Unemployed_____ Retired_____
Student_____
Employer_____________________________________
Occupation____
Work Phone #____________________________ ext. ________ May we contact you during work hours?
Y____ N____
Email Address____ Opt in to email and text notifications? Y_____
N_____
Emergency Contact Name_________________________________
Relationship_________________________________
Emergency Phone #____________________________________ (Phone number different than one above)
Pharmacy Name____________________________________
Location____
Pharmacy Phone
#____

THE INFORMATION BELOW MUST BE FILLED OUT COMPLETELY FOR US TO BE ABLE TO BILL YOUR HEALTH INSURANCE:

PRIMARY INSURANCE_____________________________ SECONDARY INSURANCE
____
Subscriber's Name________________________________ Subscriber's Name
____
Subscriber's Soc Sec #_____________________________ Subscriber's Soc Sec
#___________________________________
Subscriber's DOB_________________________________ Subscriber's DOB
____

SIGNATURE ON FILE FOR ALL PATIENTS

I authorize the release to any of my insurance companies any medical information necessary to process insurance claims for any services furnished to me by the providers of Pittsburgh Health Partners. I understand that this signature will be kept on file, and I permit a copy of this authorization to be used in place of the original. I authorize payment directly to Pittsburgh Health Partners. I understand that I am financially responsible for all charges that are incurred.

Patient Signature____

Date_____________________________

Parent Signature if patient a minor_____________________________________
Date_____________________________

REQUIRED FOR MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Pittsburgh Health Partners for any service furnished to me by these providers. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine payment for related services.

Patient Signature____ Date_____________________________

Updated 3/2022