SUPERIOR / NELSON / EDGAR FAMILY MEDICAL CENTER
PATIENT INFORMATION DEMOGRAPHIC UPDATE

PLEASE PRINT DATE_____

Patient's name_____
Last First Middle Initial

Address_____ Phone # _____

City_____ State_____ Zip Code_____ Marital Status_____

DOB_____/_____/_____ Age _____ Gender - Male_____ Female_____ Soc. Sec. #_____-_____-_____

Employer_____ Work phone # _____

Guarantor_____ DOB ___/___/_____ SS#_____-_____-_____

Contact Information_____ Relationship_____

Address_____ Phone #_____

INSURANCE INFORMATION

Primary Insurance Company_____

Policyholder_____

Policy #_____ Group #_____

Secondary Insurance_____

Policyholder_____ Group #_____

Is this a work-related visit? Yes_____ No_____

If yes, please write down date of injury and who is responsible for this bill_____

_____

LIST ANY MEDICATION ALLERGIES_____

DO YOU HAVE AN ALLERGY TO LATEX? Yes_____ No_____

RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

By signing this form, you are granting consent to the providers of Superior/Nelson/Edgar Family Medical Center, P.C. and associated physicians for the purpose of treatment. I also authorize Superior/Nelson/Edgar Family Medical Center, P.C. and associated physicians to release to Medicare carriers or the insurance carriers listed above, any information needed for this or a related claim. I permit a copy of the this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment on all future claims. I understand that even though I have some type of insurance coverage, I am responsible for payment of services including any finance charges incurred on charges older than 90 days. This signature also acknowledges that you have received a copy of our Notice of Privacy Practices.

Signature of Patient_____ Date_____