Patient Demographic Form
North Main Medical, LLC

Patient # _____

PATIENT INFORMATION

Last Name	First Name		MI
SS#	Sex	Birthdate	
Street Address	City, State, Zip		
Home Phone	Other Phone	Work Phone (include extension)	
E-Mail Address 1	E-Mail Address 2	How did you hear about our practice?	
Employment Status Full time☐ Part time ☐ Retired ☐ Self ☐ Student ☐	Marital Status Single ☐ Married ☐ Divorced ☐ Widow ☐	Student Full time ☐ Part time ☐ None ☐	
Employer Name	Employer Phone		
Employer Address	City, State, Zip		
Emergency Contact Name	Emergency Contact Relationship to Patient Spouse ☐ Parent ☐ Child ☐ Other ☐: _____		
Emergency Contact Phone	Address		

PRIMARY INSURANCE INFORMATION

Insurance Company	Claims Address	
Member #	Group # or Name	
Subscriber is: Patient ☐ Guarantor ☐ Other ☐ If other, please complete the rest of this section		
Subscriber Last Name	**Subscriber First Name**	MI
Subscriber SS#	**Subscriber Birthdate**	
Subscriber E-Mail Address	**Subscriber Phone #**	
Street Address	City, State, Zip	
Employment Status Full time☐ Part time ☐ Retired ☐ Self ☐ Student ☐	Marital Status Single ☐ Married ☐ Divorced ☐ Widow ☐	Student Full time ☐ Part time ☐ None ☐
Employer Name	Employer Address	City, State, Zip

SECONDARY INSURANCE INFORMATION

Insurance Company	Claims Address	
Member #	Group # or Name	
Subscriber is: Patient ☐ Guarantor ☐ Other ☐ If other, please complete the rest of this section		
Subscriber Last Name	Subscriber First Name	MI
Subscriber SS#	**Subscriber Birthdate**	
Subscriber E-Mail Address	Subscriber Phone #	
Street Address	City, State, Zip	
Employment Status Full time☐ Part time ☐ Retired ☐ Self ☐ Student ☐	Marital Status Single ☐ Married ☐ Divorced ☐ Widow ☐	Student Full time ☐ Part time ☐ None ☐
Employer Name	Employer Address	City, State, Zip

SIGNATURE

Payment Policy: All services rendered are charged to the patient. Necessary claim forms will be completed to expedite insurance payments. The patient is responsible for all fees, regardless of insurance coverage. Payment is required at time of service, unless other arrangements have been made. **Patients with copay are required to pay on the date of service.** I understand that I am responsible for any amount not covered by insurance. **I agree to pay any balance due, in full, within 10 days of the statement**, unless other arrangements were made, in advance. If payment is not made in a timely manner and collection action becomes necessary, the signature below shall serve as authorization to release the information necessary to the collection agency selected by the provider(s) who have provided service to me.

Insurance Authorization and Assignment: I hereby authorize the release of any medical or other information (necessary to process a claim) on my insurance carrier. I also request payment of government benefits (if any apply) either to myself or the party who accepts assignment. Furthermore, I authorize payment of medical benefits directly the medical provider(s) who have treated me or rendered services or materials.

Medicare Patients: I authorize any holder of medical or other information about me to release to Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for this or related Medicare claim. I request that payment of authorized Medicare benefits be made either to me or to the party who accepts assignment.

***Authorization for Release of Information to Email Address (if one is provided above):** We collect email addresses for the purpose of notifying patients of business announcements. We may collect and use personal data for the additional purpose of sending advertisements pertaining to specific medical conditions. We do not disclose your personally identifiable information to any outside businesses or organizations, other than for the purposes mentioned in the paragraph above regarding insurance Claims.

Treatment Consent: I consent to treatment from Steven Pribanich, MD (supervising provider), Casey Dillon PA-C or Scott A Stout, PA-C .

Signature:	Date Signed: