FALLS MEDICAL SPECIALISTS: DEMOGRAPHIC FORM

Last name: _____ First name: _____ DOB: _____ Sex: ☐M ☐F

Address: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____ Social Security #: _____

Emergency contact: _____ Phone: _____

Referring physician: _____ Phone: _____

Primary care physician: _____ Phone: _____

List any other providers who should receive your records: _____

Race: _____ Ethnicity: _____

Preferred language:

_____

Preferred pharmacies (please also list mail order and specialty pharmacy if applicable):

Local: _____ Phone: _____

Mail order/specialty: _____ Phone: _____

ACKNOWLEDGEMENT: I have been offered a copy of Falls Medical Specialists' Notice of privacy practices

Signature: _____ Date: _____

AUTHORIZATION: I authorize Falls Medical Specialists to apply for benefits on my behalf for services rendered. I request payment from my insurance company be made directly to Falls Medical Specialists. I certify that the insurance information I have provided is correct and authorize the release of any necessary information for claims. I permit a copy of this to be used in place of the original. I understand that I have the primary responsibility and obligation to pay for medical services provided when a statement is rendered.

Signature: _____ Date: _____