Transitions Center
Psychiatry & Addiction Medicine

Patient Demographic Form

Please check one: New patient ____ Updating Information: _____

Name: _____
Last First Middle Initial

Date of Birth: ____/____/_____ Social Security Number: _____-_____-_____

Marital Status (circle one): Single / Married / Widowed / Divorced / Separated Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone #: _____ Home phone #: _____ E-Mail _____

Emergency Contact: _____ _____ _____
Name Phone Number Relationship to Patient

Is there anyone that you would like to share your medical information with (circle one)? Yes No

Name: _____ Phone Number: _____

Insurance Policy Holder Information:

Name: _____ DOB: ____/____/_____
Last First

Relationship to Patient: _____ Employer: _____

Primary Insurance Information: (IMPORTANT! Even though we have a copy of your insurance card, we STILL need this portion filled out)

Insurance company: _____ ID#: _____

Group#: _____ Telephone#: _____

Primary Care Physician Information:

Name: _____

Address: _____ City: _____ State_____ Zip _____

Fax #: _____ Phone #: _____

Signature: _____ **Date:** ____/____/_____

Parent/ Legal Guardian: _____ **Date:**_____/_____/_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDOR FOR SERVICES RENDERED TO BE RENDERED IN THE FUTURE WITHOUT OBTAINING MY SIGNATURE ON EACH CLAIM SUBMITTED, AND THE SIGNATURE WILL BIND ME AS THOUGH I PERSONALLY SIGNED THE CLAIM. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESARRY. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES. IF THIS SHOULD BE REFFERED TO A COLLECTION AGENCY, I WILL BE RESPONSIBLE FOR ANY COLLECTION FEES (UP TO 45% OF THE UNPAID CHARGES AND/ OR LEGAL FEES). I HAVE READ AND UNDERSTAND THE OFFICE POLICY AND PROCEDURES.