



## Patient Demographic Information

Last Name: \_\_\_\_\_ M.I. \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ \ \_\_\_\_ \ \_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Sex:  Male  Female

Primary Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

Home  Cell  Work

Home  Cell  Work

Preferred Language:  English  Spanish  Other: \_\_\_\_\_

Race:  American Indian  African American  White  Declined  Other: \_\_\_\_\_

Ethnicity:  Central American  Cuban  Dominican  Hispanic / Latino  Mexican

Not Hispanic / Latino  Puerto Rican  Spaniard  Declined  Other: \_\_\_\_\_

Your e-mail address will be kept internally, it will be used to create your Patient Portal account so that you may review your account online, and submit questions to your doctor. We may email you, if you for appointment reminders or other office related notifications. You may, if you choose, opt of these communications

Email Address: \_\_\_\_\_  No Email

Mailing Address 1: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address 1: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employment Status:  Full Time  Part Time  Retired  Self Employed  Unemployed

Marital Status:  Married  Divorced  Single  Separated  Widowed

Spouses Name: \_\_\_\_\_ Phone: \_\_\_\_\_



**Emergency Contacts:** In the event of an emergency, please contact:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

Home  Cell  Work

Home  Cell  Work

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

Home  Cell  Work

Home  Cell  Work

People authorized to discuss your financial account:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

People authorized to discuss your medical treatment:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

**Patient Insurance Information:** Please present your insurance card with this form. Patients will be billed directly if insurance cards are not supplied.

Primary Insurance Co: \_\_\_\_\_ Date Issued: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insured Party's Name: \_\_\_\_\_ Relationship to the Insured: \_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_ Date Issued: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insured Party's Name: \_\_\_\_\_ Relationship to the Insured: \_\_\_\_\_

I, the undersigned, authorize Taos Medical Group to release my Billing Information to my insurance carrier. All services rendered will be charged to the patient. Necessary forms will be completed to expedite payments and direct billing. If you want supplemental insurance carriers billed, you must supply that information. The patient is responsible for all fee regardless of coverage as your contract is with your insurance company. Co-payments are due at the time of service, upon arrival to our office. I understand that I am ultimately responsible for all charges incurred for medical services.

I have received and reviewed the Patient Privacy Notice

Signature: \_\_\_\_\_ Date: \_\_\_\_\_