BCT MEDICAL ASSOCIATES

PATIENT DEMOGRAPHICS FORM

TODAY'S DATE:______________

PATIENT'S NAME:____________________ _________________________ SSN#: _____- _____ - ______
(Last) (First)

BIRTH DATE:_____/____/_______ SEX: M___F___ STATUS: S ___M___D___W____

ADDRESS:____APT _______________

CITY:_____________________________STATE:______________________ZIP:________________________

HOME PHONE:__________________________________ CELL PHONE:_____________________________

EMAIL:____

REFERRING PHYSICIAN:__________________________________PHONE:___________________________

PRIMARY CARE PHYSICIAN:_______________________________PHONE:___________________________

ADDRESS:____

PHARMACY:____PHONE:___________________________

EMPLOYER:____OCCUPATION: _____________________

ADDRESS:____ PHONE:___________________________

EMERGENCY CONTACT:____________________________RELATIONSHIP TO PATIENT:_________________

PHONE:____________________CELL:_________________

PRIMARY INSURANCE INFORMATION

(Please complete this information in full; we will copy front/back of insurance card)

INSURANCE COMPANY: ____

POLICY HOLDER'S NAME: ________________________________ DATE OF BIRTH:____________________

POLICY/ID NUMBER: ________________________________ GROUP ID#:____________________________

INSURANCE PHONE #:_____________________________

SECONDARY INSURANCE INFORMATION

(Please complete this information in full; we will copy front/back of insurance card)

INSURANCE COMPANY: ____

POLICY HOLDER'S NAME: ________________________________ DATE OF BIRTH:____________________

POLICY/ID NUMBER: ________________________________ GROUP ID#:____________________________

INSURANCE PHONE #:_____________________________

WORKER'S COMPENSATION/MOTOR VEHICLE? YES_______ NO________ DOA:_________________

INSURANCE: ____CLAIM #:_______________________________

ADJUSTER NAME: ____________________________________ADJUSTER PHONE #:___________________

ADJUSTER FAX: ______________________________________PRECERT #:____________________________

ATTORNEY NAME: ___________________________________ PHONE#:_______________________________