

**TRI-CITY FAMILY MEDICINE AND URGENT CARE CLINIC, PLLC**  
**107 Hyannis Drive\* Holly Springs, NC 27540-8336**  
**PHONE (919)363-8666\* FAX (919)363-8668**  
**Website: www.tricityfamily.com**

**PATIENT DEMOGRAPHIC FORM**

(THIS FORM IS TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES)

TODAY'S DATE: \_\_\_\_\_ MEDICAL RECORD# \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

SSN# \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ SEX: M F

ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ CELL/WORK PHONE (\_\_\_\_) \_\_\_\_\_

\* REFERRING PHYSICIAN \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

\* PRIMARY CARE PHYSICIAN \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PARENT NAME (IF APPLICABLE) \_\_\_\_\_

SSN# \_\_\_\_\_ EMPLOYER \_\_\_\_\_

PHONE (\_\_\_\_) \_\_\_\_\_ OCCUPATION \_\_\_\_\_

\*EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

PHONE (\_\_\_\_) \_\_\_\_\_ CIRCLE ONE: **HOME OFFICE CELL OTHER**

**\*PRIMARY INSURANCE INFORMATION**

(We will make a copy of your Insurance Card. However, we do request that you fill in the information below)

INSURANCE CO \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

CLAIMS ADDRESS \_\_\_\_\_

ID# \_\_\_\_\_ GROUP# \_\_\_\_\_ POLICY HOLDER \_\_\_\_\_

POLICY HOLDER'S EMPLOYER \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ POLICY HOLDER'S BIRTHDATE \_\_\_\_\_

**\*\*CONTINUED\*\***

**RELEASE OF MEDICAL INFORMATION**

I authorize Tri-City Family Medicine and Urgent Care Clinic, PLLC, to release the medical records concerning my son/daughter/self to any physician, hospital, or agency involved in the care of the patient listed.

**ASSIGNMENT OF MEDICAL BENEFITS**

I authorize my insurance carrier to assign all surgical and or medical benefits, if applicable, to Tri-City Family Medicine and Urgent Care Clinic, PLLC. I also authorize release of medical information necessary to process all medical insurance claims.

**PAYMENT POLICY**

Co-payments are to be collected at the time services are received. We accept cash, checks, Visa and Master Card. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be **responsible** for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

**CANCELLATION POLICY**

Our office requests that if an appointment needs to be cancelled that we receive notice no later than 4 hours prior to the appointment. We reserve the right to charge \$15.00 for a "no show" appointment, to be collected on or before your next appointment.

**REFERRAL POLICY**

I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance company. Failure to do so will result in charges being billed directly to myself.

**I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION AND PAYMENT POLICIES.**

X \_\_\_\_\_ X \_\_\_\_\_

Signature of responsible party Date, read and sign.