TRI-CITY FAMILY MEDICINE AND URGENT CARE CLINIC, PLLC
107 Hyannis Drive* Holly Springs, NC 27540-8237
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 (_____) ___________________

RACE (CIRCLE ONE): AMERICAN INDIAN/ALASKA ASIAN BLACK/AFRICAN AMERICAN CAUCASIAN PACIFIC ISLANDER OTHER RACE DECLINED

ETHNICITY (CIRCLE ONE): HISPANIC NON-HISPANIC DECLINED

MARITAL STATUS (CIRCLE ONE): DIVORCED LEGALLY SEPARATED

LANGUAGE_____________________ MARRIED SINGLE WIDOWED

***EMAIL ADDRESS**: ____

*__PROVIDER PREFERENCE:__ **CHAITANY PATEL, MD** **MARIA OFFNER, PA-C**

*__HOW DID YOU HEAR ABOUT US?____

PARENT(S) NAME (IF PT IS A MINOR) ____

SSN# __________________________ EMPLOYER ____________________ _________________

PHONE (_____) _________________ OCCUPATION ____________________________________

***EMERGENCY CONTACT** _____________________ RELATIONSHIP TO PATIENT ________

PHONE (_____) _____________ CIRCLE ONE: **HOME OFFICE CELL OTHER**

DO YOU HAVE AN EXISTING ADVANCE DIRECTIVE/LIVING WILL/POWER OF ATTORNEY?
YES____ NO____ ***N/A____(for pediatric patients only)***

*****PREFERRED CONTACT METHOD: EMAIL HOME PHONE WORK PHONE CELL PHONE**

***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** ____________

****SECONDARY INSURANCE INFORMATION**

INSURANCE CO______________________________ PHONE (____) ____________________________

CLAIMS ADDRESSS ____

ID#____________________ **GROUP#**________________**POLIC HOLDER**_______________________

POLICY HOLDER'S EMPLOYER____

HOME PHONE (____) ______________________ **POLICY HOLDER'S BIRTHDATE**______________

If you have **two** insurances that you wish for us to file, please note that we will send medical claims to primary insurance and any deductibles, coinsurance or balances that are **NOT covered** by secondary insurance policies, **will be** patient responsibility.

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.

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. IT IS IMPORTANT TO PROVIDE US WITH ACCURATE INFORMATION REGARDING YOUR PRIMARY & SECONDARY INSURANCE. IF THE INFORMATION IS *INACCURATE*, YOU MAY BE HELD LIABLE FOR YOUR VISIT. BY SIGNING BELOW, YOU ARE INDICATING THAT THE INFORMATION ABOVE IS CORRRECT.

X ____ ________________

Signature of responsible party Date