



255 SE 17th St
 Ocala, FL 34471
 Phone: (352) 509-6446
 Fax: (877) 583-4671

DEMOGRAPHIC FORM

Today's date:			How did you hear about us?			
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Mailing address:(Where you receive your mail)		Social Security no.:	Home phone no.:		Cell phone no.:	
P.O. box:		City:	State:	ZIP Code:		
Current: _____						
Occupation:		Employer and address of employer:		Employer phone no.:		
Email address:						

INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.:		
Is this person covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance		<input type="checkbox"/> BC/BS	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> United Healthcare	<input type="checkbox"/> Workers Comp
<input type="checkbox"/> Auto Insurance	<input type="checkbox"/> Other					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:				
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:
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The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Express Care of Ocala or insurance company to release any information required to process my claims.			
Patient/Guardian signature			Date