above all medical
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:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	Is not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ 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? ❑ Yes ❑ No

Please indicate primary insurance ❑ BC/BS ❑ Medicare ❑ Medicaid ❑ United Healthcare ❑ Workers Comp ❑ Auto Insurance ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): Subscriber's name:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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 Above All Medical or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*