

**DEMOGRAPHIC FORM****(Please Print)**

Today's date:							
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	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:					Home phone no.: ( )		
P.O. box:	City:		State:		ZIP Code:		
Occupation:		Employer:			Employer phone no.: ( )		
Chose clinic because/Referred to clinic by (please check one box):							
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			

INSURANCE INFORMATION							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: ( )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:			Employer phone no.: ( )		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Name of primary insurance:		Subscriber's name:		Group no.:		Policy no.:	
Subscriber's name:			Birth date: / /	Group no.:		Policy no.:	Co-payment: \$
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:		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		

**IF APPLYING FOR A FINANCIAL HARDSHIP DISCOUNT:**

If applying for a Financial Hardship Discount, please see immunization receptionist for additional paperwork to complete and verify qualifications.

**AUTHORIZATIONS AND AGREEMENTS**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I have received the Patient Financial Policies and understand that I am financially responsible for any balance. I also authorize Clermont County Public Health or insurance company to release any information required to process my claims.

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date