

FLATON ADDEPT CENTER
San Luis Obispo, California 93401

Patient Demographic/Insurance Form - (18 and over)

Patient Name: _____ **DOB:** ____ / ____ / ____

_____ First Middle Last

Patient Information

Address: _____
Street Address City State Zip

Mailing Address (if different from address above):

Street Address City State Zip

Cell Phone : _____ Text: Y / N Home Phone: _____

Email: _____

Preferred method of contact: Cell call Cell text Home call Email

Gender: M / F

Marital Status: Married Single Widowed Divorce Separated Domestic Partner

Spouse Name: _____ Home/Cell Number: _____

Patient Employment Status: Full Time Part Time None Student

Employer: _____ Occupation: _____

School: _____

Primary Care Physician

Primary Care Physician: _____

Office Phone Number: _____ Fax Number: _____

Address: _____
Street Address City State Zip

Please complete information continued on page 2

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Patient Demographic/Insurance Form - (18 and over)

Patient Name: _____ **DOB:** ____ / ____ / ____

_____ First Middle Last

Primary Insurance Provider: _____

Insured's Name: _____ Male Female

Relationship to Patient: Self Parent/Guardian Spouse Child Other Insured's DOB: ____ / ____ / ____

Member ID Number: _____ Group Number: _____

Secondary Insurance Provider: _____

Insured's Name: _____ Male Female

Relationship to Patient: Self Parent/Guardian Spouse Child Other Insured's DOB: ____ / ____ / ____

Member ID Number: _____ Group Number: _____

Emergency Contact:

Name: _____ DOB: ____ / ____ / ____

Relationship to Patient: Parent/Guardian Spouse Child Other _____

Phone Number: _____ Email: _____

Address: _____

Street Address City State Zip

Responsible Party for Financial Payment

Name: _____ DOB: _____

Relationship to Patient: Self Parent/Guardian Spouse Child Other _____

(If other than self) Phone Number: _____ Email: _____

Address: _____

Street Address City State Zip

Social Security # _____ - _____ - _____

Initial _____ By signing below, I acknowledge that the information in this form is correct to the best of my knowledge, and I acknowledge, understand and agree to the Office Policies detailed in the Patient Agreement & Consent form.

Responsible party signature _____ Date: _____