ERIC R NELSON MD PC
928-776-1004 | Office
928-776-1276 | Fax

PATIENT DEMOGRAPHIC INFORMATION

SS# _____ PATIENT'S NAME _____
Last Name First Name Middle Initial

DATE OF BIRTH _____ SEX: ○ M ○ F MARITAL STATUS: ○ S ○ M ○ W ○ D

MAILING ADDRESS _____ APT _____

CITY _____ STATE _____ ZIP _____

LOCAL ADDRESS _____ APT _____

CITY _____ STATE _____ ZIP _____

HOME # _____ CELL # _____ WORK # _____

REFERRING PHYSICIAN _____ PHONE # _____

PRIMARY CARE PHYSICIAN _____ PHONE # _____

PATIENT EMPLOYER _____ Is this an accident? ○ Job ○ Auto ○ Injury

IF ACCIDENT: Date of Injury _____ Where did injury occur? _____
City State

*** This office does not accept workman's compensation ***

PRIMARY INSURANCE

Ins. Co. Name _____
Policy/Pt ID _____
Group # _____
Relation to Patient _____
Insured's Name _____
Insured's Date of Birth _____ ○ M ○ F
Insured's Employer _____
Insured's SS# _____

SECONDARY INSURANCE

Ins. Co. Name _____
Policy/Pt ID _____
Group # _____
Relation to Patient _____
Insured's Name _____
Insured's Date of Birth _____ ○ M ○ F
Insured's Employer _____
Insured's SS# _____

WHO MAY RECEIVE INFORMATION REGARDING YOUR PROTECTED HEALTH INFORMATION? (Check all that apply)

Spouse Name _____ Phone # _____
Children Name _____ Phone # _____
Children Name _____ Phone # _____
Parent/Guardian _____ Phone # _____
Parent/Guardian _____ Phone # _____
Significant Other/Friend _____ Phone # _____

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

May we leave messages regarding test results and appointments on your answering machine? ○ YES ○ NO

DATE _____ SIGNATURE _____
Signed: ○ Patient ○ Parent ○ Guardian

IF YOU HAVE TWO INSURANCE COMPANIES, PLEASE PRESENT BOTH CARDS SO THAT WE MAY FILE WITH YOUR SECONDARY CARRIER FOR ANY BENEFITS DUE YOU.