Agave Surgical Associates, PC

PATIENT DEMOGRAPHICS FORM
(PLEASE PRINT CLEARLY AND COMPLETE ALL LINES)

TODAY'S DATE_____

NAME: _____**PREFERRED NAME**: _____
LAST FIRST MIDDLE

SOCIAL SECURITY #: _____ - ___ - _____ **DATE OF BIRTH**: ____ /____/_____**AGE**: _____ **SEX**: M F NB OTHER

STREET ADDRESS: _____
APT/UNIT: _____

PO BOX: _____ **CITY:** _____ **STATE:** _____
ZIP: _____

HOME PHONE: ( ) _____ CELL PHONE: ( )_____

EMAIL:
_____

RACE: _____ **PREFERRED LANGUAGE:** _____ **ETHNICITY:** _____

BIRTH STATE: _____ **COUNTRY OF ORIGIN:** _____**MARITAL STATUS: Married Single Widow Divorced**

PREFERRED PHARMACY: _____ **CROSS STREETS:** _____

PHARMACY ADDRESS:
_____

PRIMARY CARE PHYSICIAN: _____**PHONE #:** _____

REFERRING PHYSICIAN: _____**PHONE #:** _____

EMPLOYMENT INFORMATION
Employment Status: Employed Not Employed Retired Not Employed Self Employed Military
Employer name:_____ **PHONE #:** _____
Address: _____ **City:**_____ **State:** _____ **Zip:** _____
Occupation/Job Title:
_____

EMERGENCY CONTACT

(OVER FOR PAGE 2)

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Name: _____ Relationship:_____ Legal Guardian: Y N
Address: _____ City:_____ State: _____ Zip: _____
Phone # ( )_____, ( )_____

LIVE-IN FACILITY
Name:_____ Case Manager/Contact:_____
Address: _____ City:_____ State: _____ Zip: _____
Phone # ( )_____, ( )_____

IS YOUR VISIT RELATED TO A JOB INJURY? Y N IF YES, DATE OF INJURY: _____ / _____ / _____

EMPLOYER AT TIME OF INJURY: _____ PHONE: ( )_____

PLEASE PROVIDE A COPY OF THE WORKERS COMPENSATION INSURANCE CARRIER AND CLAIM NUMBER.

INSURANCE – PLEASE PRESENT ALL INSURANCE CARDS AND PHOTO ID AT CHECK IN
(If you are unable to provide insurance cards, please complete the section below.)

Primary Insurance Plan Name: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Insurance/Member ID: _____ Group # (if any): _____

Policy Holder's SSN: _____ - ___ - _____ Is your insurance provided through your employer? Y N

Secondary Insurance Plan Name: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Insurance/Member ID: _____ Group # (if any): _____

Policy Holder's SSN: _____ - ___ - _____ Is your insurance provided through your employer? Y N

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____ **Check here if you will SELF-PAY for services.**

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