PATIENT DEMOGRAPHICS

Primary policy holder: _____ Date of Birth: _____

Dependent(s): _____ Date of Birth: _____

Dependent(s): _____ Date of Birth: _____

Dependent(s): _____ Date of Birth: _____

Relationship to primary policy holder: _____

Address of primary policy holder: _____

City: _____ Zip Code: _____

Address of dependent: _____

Telephone: Work: _____Home: _____

Cell: _____Email address: _____

M / F Married/Single/Divorced/Widowed/Other (circle appropriate choices)

Insurance for Primary person insured:

Insurance Company: _____

Policy Number: _____

Group Number: _____

Co Pay$/PCP visit %: _____

Other PCP: _____

Please indicate how you heard about me: _____

Emergency Contact: Name and phone number: _____

_____

****HIPPA requires that you give permission to Dr. Sellars to share information with anyone that may contact her regarding your health care otherwise your health information may not legally be shared. Please specify if there is anyone with whom your information may be shared: _____

_____

Your insurance company requires a signature to be on file.

Signature and date: _____