PATIENT DEMOGRAPHICS

Please fill in even if not covered by insurance

Patient Name: _____Date of Birth_____

Dependent(s): _____Date of Birth_____

Primary policy holder: _____Date of Birth_____

Address of primary policy holder: _____

City:_____ Zip Code: _____

Telephone: Work: _____Home: _____

Cell: _____email address:_____

M/F Married/Single/Divorced/Widowed/Other

Insurance for Primary person insured:

Provider: _____

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: _____