ON DEMAND

PATIENT REGISTRATION INFORMATION

Please print and complete all sections of this form

LAST NAME: _____ FIRST NAME: _____ INITIAL: _____

DATE OF BIRTH: _____ SEX: ☐ M ☐ F SOCIAL SECURITY: _____

MARITAL STATUS: ☐ S ☐ M ☐ W ☐ D ☐ OTHER MAIDEN NAME (IF APPLICABLE) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ EMAIL ADDRESS: _____

SPOUSE NAME: _____

RACE: ☐ White ☐ Black ☐ Asian ☐ American Indian/Alaskan Native ☐ Hispanic ☐ Other _____

ETHNICITY: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unreported/Refused

LANGUAGE: ☐ English ☐ Spanish ☐ French ☐ Arabic ☐ Chinese ☐ Sign Language

EMPLOYEER: _____ WORK PHONE: _____

Responsible Party Information *(for patients under 18 and other dependent patients)*

NAME: _____ (Last) _____ (First) _____ (Middle Initial) _____ (Relationship to Patient)

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ SEX: ☐ M ☐ F SOCIAL SECURITY: _____

TELEPHONE #: _____ ☐ HOME ☐ CELL ☐ OTHER _____

Emergency Contact

NAME: _____ PHONE: _____ RELATIONSHIP TO PATIENT: _____

Patient's Insurance Information

PRIMARY POLICY

POLICY HOLDER NAME: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____

INSURANCE CARRIER: _____ POLICY # _____

SECONDARY POLICY

POLICY HOLDER NAME: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____

INSURANCE CARRIER: _____ POLICY # _____

ON DEMAND

Patient's Name: _____
DOB: _____
TODAY'S DATE: _____

PATIENT REGISTRATION FORM (continued)

Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to On Demand. I authorize this healthcare provider to release any information necessary to ensure payment by my insurance company. I understand I am financially responsible for all charges not covered by insurance, including patient co-pay, deductible, non-covered services, or vaccinations. **I understand that my account may be turned over to collections for failure to make payments within 90 days upon receiving my statement.**

_____ _____
Signature of Patient or Legal Guardian *Date*

Acknowledgement of Notice of Privacy Practices

The notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices. A copy is available upon request.

_____ _____
Signature of Patient or Legal Guardian *Date*