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Lexington KY 40504
Phone: 859-263-2222
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Adult Demographics Form

Patient Information

Title _____ Last Name_____

First Name_____ M.I. _____

Gender _____ Date of Birth _____ Social Security Number _____

Address _____ City/State _____

Zip Code _____ Home phone _____ Cell Phone _____

Work Phone _____Driver's License Number _____

Email Address_____

Preferred Contact Method _____ Preferred Time of Day _____

Marital Status_____ Current Employment Status_____

Occupation _____ Employer _____

Employment Address_____

City/State _____ Zip Code _____

Spouse's Name (Last, First, M.I.) _____

Spouse's Current Employment Status _____Occupation _____

Spouse's Employer _____

Responsible Party for Payment

Responsible Party for Payment: [ ] Patient [ ] Spouse [ ] Other

Please fill out the following for the Responsible Party below if different than from above.

Responsible Party (Last, First, M.I.) _____

Title _____ DOB _____ SSN _____Gender _____

Address _____ City/State _____

Zip Code _____ Home phone _____Cell Phone _____

Email Address_____ Work Phone _____

Marital Status_____ Current Employment Status_____

Occupation _____ Employer _____

Employment Address_____

City/State _____ Zip Code _____

Insurance Information

Name of primary insurance (enter "NA" if self-pay) _____

Name of Insured (Last, First, M.I.) _____

Name of Policy Holder (Last, First, M.I.) _____

Primary Insurance State _____ Policy Holder's Relationship to Patient _____

Insurance ID number _____

Insurance Group number _____

Policy Effective Dates _____

Name of secondary insurance (enter "NA" if self-pay) _____

Name of Insured (Last, First, M.I.) _____

Name of Policy Holder (Last, First, M.I.) _____

Primary Insurance State _____ Policy Holder's Relationship to Patient _____

Insurance ID number _____

Insurance Group number _____

Policy Effective Dates _____

Emergency Contact Information

Emergency Contact Name _____

Emergency Contact Relationship to Patient _____

Home Phone _____ Work Phone _____ Cell Phone _____

Physician Information

Referring Physician Name _____

Referring Physician Practice Name _____

Practice Address _____

City/State _____ Zip Code _____ Phone _____

Primary Care Physician Name (if different from Referring Physician)

_____

Primary Physician Practice Name _____

Practice Address _____

City/State _____ Zip Code _____ Phone _____

How did you hear about Horizon Headache Center?

_____

I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of my account for any professional services rendered. I am also responsible for recognizing insurance status including, but not limited to, benefits and allowable visits. I have read all the information on this page and certify that the information I provided is true and correct to the best of my knowledge. I also agree to notify Horizon Headache Center of any changes in the above information.

_____ _____

PATIENT SIGNATURE DATE