Patient Demographic Form

Required by the state of N.C.

Patient Information

Name: _____ Age: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Married ☐ Single ☐ Widowed ☐ Divorced ☐

Male ☐ Female ☐ Race: _____

American Indian/Alaskan Native
Asian/Pacific Islander
African American (non-Hispanic)
African American
Caucasian
Hispanic
Other
Unknown
Caucasian (non-Hispanic)

Medical Doctor: _____

Office use only

Primary Insurance Information: _____ Card copied Y N

Secondary Insurance Information: _____ Card copied Y N

Tertiary Insurance Information : _____ Card copied Y N

Employment Information *(For Disability only)*

Employer: _____ Phone: _____

Address: _____

Is condition work related? Y N Date of injury: _____

Emergency Notification

Name: _____ Phone: _____

Relationship: _____

Release of Authorization/Assignment of Benefits

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

_____ _____

Patient Signature Date (date of surgery)