



St. Clair Specialty Physicians, P.C.

**PATIENT DEMOGRAPHIC FORM**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Sex: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone Number: \_\_\_\_\_

**Nearest Relative or Person we may contact in case of an emergency (outside of your own home)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS AUTHORIZATION FOR TREATMENT:**

I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that benefits be made payable to the provider on my behalf or to myself. I understand that I am financially responsible for the charges not covered by my insurance carrier.

Patient or Authorized Representative: \_\_\_\_\_

\_\_\_\_\_  
Primary Care Physician                      Address                      Phone

Date: \_\_\_\_\_