Demographic Form

(405)732-7777

Last Name:_____First Name:_____MI:____

Sex:_____Date of Birth:_____Social Security#_____

Address:_____

City:_____State:_____zip:_____

Home Phone:_____Cell Phone:_____

Employer:_____Work #:_____

Emergency Contact:

Name:_____Relationship:_____

Phone:_____Alternate Phone_____

Who Referred You to This Office?_____

Family Doctor in Different?_____

Primary Insurance Name:_____ID#:_____Groups#:_____

Insured's Name:_____Social Security #:_____DOB:_____

Secondary Insurance Name:_____ID#:_____Groups#:_____

Insured's Name:_____Social Security #:_____DOB:_____

ASSIGNMENT OF BENEFITS TO PROVIDER:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CLAIMS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES RENDERED UNLESS ARRANGEMENTS ARE MADE IN ADVANCE. PLEASE READ AND SIGN THE FOLLOWING AUTHORIZATION AND ASSIGNMENT.

I HEREBY AUTHORIZE RELEASE OF INFORMATION FOR INSURANCE CLAIMS PURPOSES AND IN EFFORT TO ASSURE PAYMENT OF MY BILL. MY SIGNATURE INDICATES THAT I HAVE READ ALL OF THE ABOVE AND HEREBY GRANT INSURANCE COMPANIES REQUEST FOR DOCUMENTS ALSO HEREBY ASSIGN TO CHRISTOPHER JORDAN, MD, LLC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS.

PATIENT / GUARANTOR SIGNATURE:_____Date:_____

Office Use Only

What are we seeing the patient for?_____How did it happen?_____

Insurance Effective Date:_____2nd Effective Date:_____

Spoke With:_____

Copay:_____Deductible:_____DedMet:_____ CoInsurance:_____

Precert: MRI_____Out pat. Surgery:_____In pat Surgery:_____

APPT DATE:_____ APPT TIME:_____