Cumberland Family Practice, P.C.

Patient Demographics Form

Patient Name: «FirstName» «LastName»	**Email:**	
Mailing Address:		
Home Phone:	**Cell Phone:**	**Work Phone:**
Date of Birth:	**Sex**:	
Social Security Number:	**Marital Status**:	
Race: **Language:**	**Ethnicity: Hispanic Not Hispanic**	
Patient's Employer:		
Retired: Yes / No		
Responsible Party:	**Emergency Contact Name:**	
Responsible Party Address:	**Emergency Contact Phone Number:**	
Responsible Party Date of Birth:	**Relationship:**	
Responsible Party SSN:		
Primary Insurance:	**Secondary Insurance:**	
Prim. Insurance Address:	**Sec. Insurance Address:**	
Phone Number:	**Phone Number:**	
Subscriber Name:	**Subscriber Name:**	
Date Of Birth:	**Date Of Birth:**	
Subscriber ID:	**Subscriber ID:**	
Group Number:	**Group Number:**	
Pharmacy Name:		
Pharmacy Address:		
Pharmacy Number:		
Do you have a Living Will? ☐ Yes ☐ No	Do you have Power of Attorney? ☐ Yes ☐ No	

- ***Assignment and Release***
  I, the undersigned, certify that I or my dependent have insurance with the previously stated insurance carrier and assign to Cumberland Family Practice, P.C. all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize Cumberland Family Practice, P.C. to release all information necessary to secure payment of benefits. I further authorize the use of this signature on all insurance submissions. I also consent to treatment for my condition as directed by my physician. There will be a $25.00 charge for all returned checks.
- ***Consent for Prescription History***
  I consent to allow Cumberland Family Practice, P.C. to access my prescription history when integral to my care or deemed medically necessary.
- ***Protected Health Information***
  I have received the brochure on Privacy Practices. I grant permission for **Cumberland Family Practice, P.C.** to discuss my personal information regarding my care, treatment or financial obligations to the people I have designated below. Authorization will remain in effect until revoked in writing.
  Designated Persons:_____

I have reviewed all of the statements above to include Assignment and Release, Consent for Prescription History and the Protected Health Information and agree to all policies.

_____ _____

Signature of Patient/Legal Guardian Date