FLATON ADDEPT CENTER
San Luis Obispo, California 93401

Patient Demographic/Insurance Form - (18 and over)

Patient Name: _____ **DOB:**____/____/____
First Middle Last

Patient Information

Address: _____
Street Address City State Zip

Mailing Address (*if different from address above*):

_____
Street Address City State Zip

▢ Cell Phone :_____ Text: ▢ Y / ▢ N ▢ Home Phone:_____

Email:_____

Preferred method of contact: ▢ Cell call ▢ Cell text ▢ Home call ▢ Email

Gender: ▢ M / ▢ F

Marital Status: ▢ Married ▢ Single ▢ Widowed ▢ Divorce ▢ Separated ▢ Domestic Partner

Spouse Name: _____ Home/Cell Number: _____

Patient Employment Status: ▢ Full Time ▢ Part Time ▢ None ▢ Student

Employer: _____ Occupation: _____

School: _____

Primary Care Physician

Primary Care Physician:_____

Office Phone Number:_____Fax Number: _____

Address: _____
Street Address City State Zip

Please complete information continued on page 2

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Patient Name: _____ DOB:____/____/____
First Middle Last

Primary Insurance

Insured's Name:_____ ▢ Male ▢ Female
Relationship to Patient: ▢ Self ▢ Parent/Guardian ▢ Spouse ▢ Child ▢ Other Insured's DOB: ____/____/_____

Member ID Number: _____Group Number: _____

Secondary Insurance

Insured's Name:_____ ▢ Male ▢ Female
Relationship to Patient: ▢ Self ▢ Parent/Guardian ▢ Spouse ▢ Child ▢ Other Insured's DOB: _____/_____/_____
Member ID Number: _____ Group Number: _____

Emergency Contact:

Name: _____ DOB: ____/_____/_____

Relationship to Patient: ▢ Parent/Guardian ▢ Spouse ▢ Child ▢ Other _____
Phone Number: _____Email: _____
Address: _____
Street Address City State Zip

Responsible Party for Financial Payment

Name:_____ DOB: _____
Relationship to Patient: ▢ Self ▢ Parent/Guardian ▢ Spouse ▢ Child ▢ Other _____
(If other than self) Phone Number: _____ Email:_____

Address: _____
Street Address City State Zip

Social Security # _____-_____-_____

Initial _____ By signing below, I acknowledge that the information in this form is correct to the best of my knowledge, and I acknowledge, understand and agree to the Office Policies detailed in the Patient Agreement & Consent form.

Responsible party signature _____ Date: _____