Patient Demographic Information

Last Name: _____ M.I. _____ First Name: _____

Date of Birth: _______________ SSN: _____ - ____ - _____ Sex: ☐ Male ☐ Female

Primary Phone: _____ Alternative Phone: _____

☐ Home ☐ Cell ☐ Work ☐ Home ☐ Cell ☐ Work

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ American Indian ☐ African American ☐ White ☐ Declined ☐ Other: _____

Ethnicity: ☐ Central American ☐ Cuban ☐ Dominican ☐ Hispanic / Latino ☐ Mexican

☐ Not Hispanic / Latino ☐ Puerto Rican ☐ Spaniard ☐ Declined ☐ Other: _____

Your e-mail address will be kept internally, it will be used to create your Patient Portal account so that you may review your account online, and submit questions to your doctor. We may email you, if you for appointment reminders or other office related notifications. You may, if you choose, opt of these communications

Email Address: _____ ☐ No Email

Mailing Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Physical Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Unemployed

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Spouses Name: _____ Phone: _____

Emergency Contacts: In the event of an emergency, please contact:

First Name: _____ Last Name: _____

Primary Phone: _____ Alternative Phone: _____

☐ Home ☐ Cell ☐ Work ☐ Home ☐ Cell ☐ Work

First Name: _____ Last Name: _____

Primary Phone: _____ Alternative Phone: _____

☐ Home ☐ Cell ☐ Work ☐ Home ☐ Cell ☐ Work

People authorized to discuss your financial account:

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

People authorized to discuss your medical treatment:

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

Patient Insurance Information: Please present your insurance card with this form. Patients will be billed directly if insurance cards are not supplied.

Primary Insurance Co: _____ Date Issued: _____

Policy Number: _____ Group Number: _____

Insured Party's Name: _____ Relationship to the Insured: _____

Secondary Insurance Co: _____ Date Issued: _____

Policy Number: _____ Group Number: _____

Insured Party's Name: _____ Relationship to the Insured: _____

I, the undersigned, authorize Alchemy Integrated Medicine to release my Billing Information to my insurance carrier. All services rendered will be charged to the patient. Necessary forms will be completed to expedite payments and direct billing. If you want supplemental insurance carriers billed, you must supply that information. The patient is responsible for all fee regardless of coverage as your contract is with your insurance company. Co-payments are due at the time of service, upon arrival to our office. I understand that I am ultimately responsible for all charges incurred for medical services.

☐ I have received and reviewed the Patient Privacy Notice

Signature: _____ Date: _____