SimplyCare
151 Adams Lane Ste. 13
Mt. Juliet, TN 37122
Tel: 615-288-4087 Fax: 615-553-4520

Patient Demographics Form

Patient Name: (First)	**(Middle)**	**(Last)**	
Mailing Address: (Street)	**(City)**	**(State)**	**(Zip)**

Home Phone:	**Cell Phone:**	**Work Phone:**

Date of Birth:	**Marital Status:**
Social Security Number:	**Employer Name:**
Email Address:	**Race: Language:**
Emergency Contact Name:	**Emergency Contact Phone Number:**
Responsible (Guarantor) Party:	**Responsible Party Date of Birth & SSN:**
Responsible Party Address:	
Primary Insurance:	**Policy Holder Name:**
Policy ID:	**Date Of Birth:**

Secondary Insurance:	**Policy Holder Name:**
Policy ID:	**Date Of Birth:**

Primary Care Provider if not SimplyCare:	**Referring Provider or Person:**

Ok to Leave Message at Circle all that apply: Home? Work? Cell?	

Pharmacy Name and Location:	

*I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to my child or me during the period of such care to **third party payers and/or other health practitioners**. I authorize and request my insurance company to pay benefits otherwise payable to me directly to **SimplyCare.** I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependent or myself. I understand that by giving my email address I give permission to **SC** to communicate with me via email.* _____ ***Please Initial Here***

Please list below **all parties below** we are authorized to speak with regarding your account and medical information: (EX: Name of Spouse, Name of Mother)

_____ _____ _____ _____

Privacy Practice Acknowledgement

I have received the Notice of Privacy Practices (on the wall in lobby), Office Service Statement, Patient E-communication and I have been provided an opportunity to review it.

_____ _____

Patient's Signature (Parent's signature if under 18) **Date**