# MICHAEL SETZEN, MD, FACS, FAAP

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## PATIENT DEMOGRAPHIC FORM

### PATIENT INFORMATION DATE:

Patient Name: ______________________ Patient's Social Security Number: ______________________

Date of Birth: ____________ Sex: M ❍ F ❍ Marital Status? S ❍ M ❍ D ❍ W ❍ Language: ______ Race: ______

Dominant Hand: Right Hand __________ Left Hand ____________ Ambidextrious __________

Street Address: ______________________________________ Apt. No.: ______________

City: ______________________________ State: ______________ Zip Code: ____________

Home Phone: (______) ______________________ Work Phone: (______) ______________________

Cell/Pager Number: (______) ______________________ Email Address: ______________________

Emergency Contact Name/Relation: ______________________ Emergency Contact Phone: (______) ____________

Indicate: ❍ Cell ❍ Home

### GUARANTOR/PARENT INFORMATION

Responsible Party Name: ______________________ ______________________ ____________

(Last) (First) (Middle)

Relationship to Patient: ______________________ Responsible Party Date of Birth: ______________

Guarantor's Social Security Number: __________ - ______ - __________

Street Address: ______________________________________

City: ______________________________ State: ______________ Zip Code: ____________

Home Phone: (______) ______________________ Cell/Pager Number: (______) ______________________

Employer's Name: ______________________ Work Phone: (______) ______________________

Employer's Address: ______________________________________

City: ______________________________ State: ______________ Zip Code: ____________

### PATIENT's INSURANCE INFORMATION *Please provide Insurance Card and Photo ID to receptionist

Primary Insurance Company's Name: ______________________________________

Insurance Address: ______________________________________

City: ______________________________ State: ______________ Zip Code: ____________

Phone Number (______) ______________________

Name of Policy Holder: ______________________ Date of Birth: ______________________

Insurance ID Number: ______________________ Group Number: ______________________

Secondary Insurance Company's Name: ______________________________________

Insurance Address: ______________________________________

City: ______________________________ State: ______________ Zip Code: ____________

Phone Number (______) ______________________

Name of Policy Holder: ______________________ Date of Birth: ______________________

Insurance ID Number: ______________________ Group Number: ______________________

### PATIENT's REFERRAL INFORMATION

Primary Care Physician: ______________________ Phone (______) ______________________

Address: ______________________ City: ______________ State: __________ Zip: __________

Referring Physician: ______________________ Phone (______) ______________________

Address: ______________________ City: ______________ State: __________ Zip: __________

**Pharmacy:** Name: ______________________ Phone: ______________________

Address: ______________________ Fax: ______________________