

**Patient Demographic Billing Sheet**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Marital Status: \_\_\_\_\_

SSN: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Primary Insurance**

Insurance Name: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Secondary Insurance**

Insurance Name: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize payment of medical benefits to DCH Health System with my current insurance carrier as reflected above.

\_\_\_\_\_  
Date/Time Patient Signature

\_\_\_\_\_  
Date/Time Employee Signature



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Billing Sheet**



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