Tennessee Heart & Vascular

PATIENT DEMOGRAPHIC VERIFICATION FORM

Patient Name: **Patient ID:**
Appointment Date & Time: **Primary Insurance Copay:**
Appointment Provider: **Specialty Copay:**
Appointment Reason:

		UPDATE INFORMATION BELOW
Responsible Party		
Name		
Address		
Phone Number		

Patient Information		
Name		
Mailing Address		
Alternate/Local Address		
Phone Number		
Cell Phone Number		
Email Address		
Date of Birth		
Patient Sex		
Marital Status		
Age		
Social Security Number		
Emergency Name		
Emergency Phone		
Preferred Language		

Race: ❑ American Indian or Alaskan Native ❑ Asian ❑ Native Hawaiian or other Pacific Islander ❑ Black or African American ❑ White ❑ Other Race ❑ Unreported/Refused to Report

Ethnicity (Cultural Background) ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Refused to Report

Have you received medical care from any other healthcare provider since your last visit in our office? ❑ Yes ❑ No

Employer Information		
Name of Employer		
Employer Address		
Employer Phone Number		

Health Insurance		
Primary Insurance Name		
Primary Claim Address		
Primary Phone Number		
Primary Policyholder		
Primary Subscriber Number		
Primary Group Number		
Secondary Insurance Name		
Secondary Subscriber Number		
Secondary Group Number		

Pharmacy Information		
Pharmacy Name		
Pharmacy Address		
Pharmacy Phone Number		

I certify the above demographic and insurance information listed above to be correct. I hereby authorize any insurance benefits to be paid directly to the physician providing services and recognize my responsibility to pay for all non-covered services. I also authorize the physician to release any information necessary to process an insurance claim

X	**Date**