MACOMB PHYSICIANS GROUP, PLLC

Patient Demographics

_____
Last Name M. I.

_____
First Name

_____
Street Address

_____
City State

_____
Zip

_____
Email

Gender: ☐ Male ☐ Female

DOB: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Soc. Sec. #: _____

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

Lang ☐ English ☐ Spanish ☐ Other:_____

Ethnic Group ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to State

Race

☐ African American/Black ☐ Pacific Islander
☐ Asian ☐ White or Caucasian
☐ Asian Indian ☐ Filipino
☐ American Indian or Alaska Native ☐ Other
☐ Declined to State

Guarantor (Responsible Party)

☐ Same as Patient — Please complete if different from patient.

Name: _____
Last Name First Name

DOB: _____

Address: _____
Street Address

_____
City State Zip Code

Emergency Contact

Name: _____

Phone: _____

Relationship:

Employer

☐ Employed ☐ Unemployed ☐ Retired

Name: _____

Address: _____

_____

Phone:

Please notify the front desk staff if you have three insurances

Primary Ins.

Cardholder Name: _____ Insurance Co. _____
Cardholder Gender: ☐ Male ☐ Female Cardholder
Relationship: Date of Birth _____

Secondary Ins.

Cardholder Name: _____ Insurance Co. _____
Cardholder Gender: ☐ Male ☐ Female Cardholder
Relationship: Date of Birth _____

I would like information on Patient Advocacy: ☐ Yes ☐ No

- Patients must present their insurance ID card and photo ID to the receptionist for copying purposes.
- **Copayments are due at the time of service.**
- I authorize the use of my signature on all insurance claims.
- I authorize the release of any medical information to my insurance company and or other health providers.
- I authorize my insurance company to pay directly to the doctor.
- I understand that I am responsible for payments of all services not covered by my insurance company.

Signature of patient or legal representative X _____ *Date* _____