Demographics Verification Form

Demographic Information

Name: _____ Preferred Name: _____

Mailing Address: _____ County: _____

CITY STATE ZIP CODE

Date of Birth: _____ Sex: _____ Marital Status: _____

Social Secuity Number: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

OK to Leave Message: ☐ Home ☐ Cell ☐ Brief ☐ Extended Language Spoken: _____

Select One: ☐ White ☐ Black / African American ☐ Hispanic ☐ Other: _____

Primary Care Provider: _____

Employer Name: _____ Employer Address: _____

Emergency Contact

Name: _____ Phone: _____ Relation: _____

Primary Insurance

Insurance: _____ Subscriber #: _____ Group #: _____

Subscriber Address: _____

CITY STATE ZIP CODE

Insured Name: _____ Date of Birth: _____ Relation: _____

Secondary Insurance

Insurance: _____ Subscriber #: _____ Group #: _____

Subscriber Address: _____

CITY STATE ZIP CODE

Insured Name: _____ Date of Birth: _____ Relation: _____

Pharmacy Information

Name/Location: _____ Phone: _____ Alt: _____

I attest that the above information is correct and have read and understand the policies of Aylo Health, and accept my responsibility as stated in those policies. I hereby authorize release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge. I hereby allow the clinical staff of Aylo Health to view my medication history from external sources.

_____ _____

PATIENT SIGNATURE (AGES 17 AND UNDER REQUIRES SIGNATURE OF PARENT OR GUARDIAN) DATE

_____

RELATIONSHIP TO CHILD