theSwierClinic

PATIENT DEMOGRAPHICS

Dr Patrick Swier
1400 Savannah Road
Lewes, DE 19958

Swier Clinic Acct # _____

TODAY'S DATE: _____

EXP DATE: _____

Demographic and consent forms are good for twelve (12) months UNLESS information changes

Patient Information:

Last Name ***First Name*** ***Middle Initial*** ***Birth date***

Mailing Address: *(house #, street, PO box, Lot #, Apt #)* ***City*** ***State*** ***Zip Code***

Home Phone # ***Cell #*** ***Sex:*** ***Marital Status:***

Employer: *(name, address, phone#)* ***Occupation:***

Emergency Contact Name ***Phone #*** ***Relationship***

Patient Email: _____

May we call you at home? **YES NO** *May we leave a* message? **YES NO** **Soc Sec #** : _____

Guarantor Information *(required if patient is a minor)* **Relationship to patient:** _____

Last Name *First Name* *Middle Initial*

Birth Date *Social Security Number* *Employer Name & Phone #*

Insurance Information:

Primary Insurance Company: _____ ***Co-pay:*** *$*_____ ***Referral Required****?* ___ *No* ___ *Yes*

ID #: _____ *Group #:* _____

Policy Holder Name: _____ *Date of Birth:* _____

Secondary Insurance Company: _____ *Co-pay*: $_____

ID #: _____ *Group #:* _____

Policy Holder Name: _____ *Date of Birth:* _____

I consent to treatment by PATRICK SWIER, M.D., P.A. & other healthcare practioners providing services within THE SWIER CLINIC. I understand that I responsible for any and all charges (or amounts based on payment arrangements agreed to by them) that are included during my treatment and not paid or otherwise satisfied by my insurance benefits or other third party benefits. Where Medicare benefits are applicable, I certify that the information given by me in applying for payment under Title VIII of the Social Security Act is correct. I assign and request payment of authorized Medicare benefits to THE SWIER CLINIC. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine the benefits of related services. I consent to the use and disclosure of my health information for treatment, payment & healthcare operations purposes as described in The Swier Clinic's Notice of Privacy Practices.

_____ _____ _____

Signature *Date* *Swier Clinic Emp initials/date*