SCNM SOUTHWEST COLLEGE OF NATUROPATHIC MEDICINE & HEALTH SCIENCES
MEDICAL CENTER

PATIENT DEMOGRAPHIC FORM

Patient Contact Information

Legal Last Name:	Legal First Name:	Legal Middle Initial:	Nickname/AKA:

Date of Birth:	Social Security Number:	Gender: ☐Male ☐Female ☐Other________________

Marital Status:	☐Single ☐Married ☐Divorced ☐Remarried ☐Widowed ☐Separated ☐Annulled ☐Interlocutory ☐Polygamous ☐Domestic Partner ☐ Other

Language (Other than English):	E-mail Address:

Race	☐American Indian or Alaskan Native ☐Hispanic or Latino ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐Not Indicated ☐Unknown ☐White/Caucasian ☐Other_______________

Home Address:	Apt #:	City:	State:	Zip Code:

Mobile/Cell Phone:	Work Phone:	Home Phone:	Preferred Contact: ☐Mobile ☐ Home ☐ Work

Employment Status	☐Employed Full-Time ☐Employed Part-Time ☐Active Duty ☐Self-Employed ☐Not Employed ☐Student-Full Time ☐Student-Part Time ☐ Homemaker ☐Retired ☐ Disabled ☐Other

Employer:		Employer Phone:

Physician/Referral Information

Primary Care Physician:	Referring Physician:

How did you hear about us?	☐Driving By ☐ Facebook ☐Family ☐Instagram ☐ Internet Search ☐Friend ☐LinkedIn ☐ Newspaper ☐Radio ☐SCNM Employee ☐ SCNM Patient ☐Twitter ☐Physician ☐Pinterest ☐ SCNM Student ☐SCNM Physician ☐ SCNM Newsletter ☐ Yelp ☐Theater ☐YouTube ☐Yellow Pages ☐TV ☐SCNM Website

Responsible Party (Guarantor) Information

Relationship to Patient: Self (If self, skip to Emergency/Next of Kin ☐Spouse ☐Parent ☐Other ☐

Legal Last Name:	Legal First Name:	Legal Middle Initial:	Nickname/AKA:

Date of Birth:	Social Security Number:	Gender: ☐Male ☐Female ☐Other________________

Home Address:	Apt #:	City:	State:	Zip Code:

Mobile/Cell Phone:	Work Phone:	Home Phone:	Preferred Contact:
			☐Mobile ☐Home ☐Work

Employer:	

Employment Status	☐Employed Full-Time ☐ Employed Part-Time ☐Not Employed ☐Active Duty Military ☐ Self-Employed ☐Student-Full Time ☐Student-Part Time ☐Retired ☐Homemaker ☐Disabled ☐Other____________________

Emergency/Next of Kin Contact Information			
Legal Last Name:	**Legal First Name:**	**Legal Middle Initial:**	**Relationship to patient:**
Home Address:	**Apt#:**	**City:**	**State**
Mobile/Cell Phone:	**Work Phone:**	**Home Phone:**	**Preferred Contact:** ☐Mobile ☐ Home ☐ Work

Other Contact Information-Not Living with Patient					
Last Name:	**First Name:**	**Relationship to Patient:**			
Home Address:		**Apt #:**	**City:**	**State:**	**Zip Code:**
Mobile/Cell Phone:	**Work Phone:**	**Home Phone:**	**Preferred Contact:** ☐Mobile ☐ Home ☐ Work		

Insurance (If applicable) SCNM Medical Center is contracted with limited insurances	
Insurance Company:	**Phone Number:**
Name of Insured:	**Relationship to the Insured:**
Policy #:	**Group #:**

Insurance Information

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Furthermore, in the event that payment is not made on this account and it is placed with a licensed collection agency, I/we agree to pay the fees of the collection agency equal to the maximum of 50% of our outstanding balance at the time the account is placed with the agency. Should legal action also be necessary to collect the account, I/we agree to pay attorney's fees and court costs incurred for the collection.

Releases may be requested prior to specific procedures being performed (i.e., minor surgery, etc.)

Clinic Policy requires payment at time of services.

Signatures

Print Patient Name	MR Number (Office Use Only)
Patient or legally authorized individual signature	Date
Printed legally authorized individual signature	Relationship (self, parent, legal guardian, personal representative, etc.)