DEMOGRAPHIC FORM

PATIENT'S NAME:_____ Appt Date/Dr:_____
Home Address:_____ City:_____
State:_____ Zip:_____
Home Tel:_____ Work Tel:_____ext:_____ Cell:_____
Birth Date: _____ Sex :_____ Gender Identity:◯Female ◯Male Social Security #: _____
Employer: _____Occupation:_____
Email address: _____Pharmacy Name and #: _____
Legal relationship status: ◯Single ◯Married ◯Divorced ◯Widowed Are you or your partner married to someone else? ◯YES ◯NO
OB/GYN: _____ Tel #: _____
Did your OB/GYN refer you to our office ◯YES ◯NO if not how did you you hear about us?_____
Partner's Name:_____ Partner's Birth Date: _____ Social Security#: _____
Telephone #:_____ Employer:_____ Occupation:_____
Address (If different than yours): _____ Pharmacy#:_____
Home Tel:_____ Work Tel:_____ext:_____ Cell:_____
Email address: _____Current Urologist: _____Tel #:_____

PATIENT'S INSURANCE CARRIER

Insurance Co:_____
Address:_____
_____
Tel #:_____
ID #: _____
Group #: _____Spec Copay $_____
Subscriber:_____
Participating Lab:_____
(LabCorp, Quest, etc.)

SPOUSE/PARTNER INSURANCE CARRIER

Insurance Co:_____
Address:_____
_____
Tel #:_____
ID #: _____
Group #: _____Spec Copay $_____
Subscriber:_____
Participating Lab:_____
(LabCorp, Quest, etc.)

Are you covered under your spouse/partner's insurance plan? ◯YES ◯NO

***Please note that male partners must also abide by the rules set forth by their insurance. If their plans require referrals or authorizations, they must be obtained prior to services being rendered. Male partners are not covered under referrals or authorizations issued for females.

Signature:_____ Date:_____

Authorizations: I authorize RMA of Northern California physicians to release any information in the course of my examination or treatment to my insurance company. I further authorize any benefits due for services rendered to be paid directly to RMA NorCal. I understand that I am responsible for any charges not covered by my insurance and for any balance due after insurance payments. If RMA does not participate with my insurance company I also understand that payment MUST BE MADE AT THE TIME services are rendered. Please have a valid driver's license and insurance card ready for photocopy.

Signature:_____ Date:_____