Lona Sasser, D.O. LLC

Patient Demographic Form

Patient Name: _____ Date of Birth: _____

SS# _____ Policy Holder _____

Address _____ Address _____

Apt. # _____ Apt. # _____

City _____ State____ Zip _____ City _____ State ____ Zip _____

Home # _____ Cell # _____ Tel # _____

Language Spoken _____ Relationship _____

Marital Status: S M W D Referred by: _____

E-mail _____

Employer Spouse _____

_____ Spouse Employer _____

Address _____ Address _____

Phone _____ Phone _____

In case of emergency, notify:

_____ Phone _____

Nearest friend or relative not living with you:

_____ Phone _____

Medical Insurance: Medicare # _____

Primary _____ Secondary _____

Insured _____ Insured _____

ID# _____ ID# _____

Group# _____ Group# _____

Assignment of benefits to facilitate the processing of claims

a. I hereby assign all medical and or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Lona Sasser, D.O. LLC.

b. I understand that I am financially responsible for all charges whether or not paid by said by said insurance. I hereby authorize said assignor to release all information necessary to secure the payment.

c. Payments MUST be made at the time of each visit, unless prior payment arrangements have been made. A surcharge of 35% will be added to any accounts sent to our collections department.

I have read and understand the above.

Signed: _____ Date: _____