CLERMONT COUNTY PUBLIC HEALTH - 2400 Clermont Center Drive, Suite 200, Batavia, OH 45103

DEMOGRAPHIC FORM
(Please Print)

Today's date:	

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:			Home phone no.: ( )		
P.O. box:	City:	State:	ZIP Code:		
Occupation:	Employer:	Employer phone no.: ( )			
Chose clinic because/Referred to clinic by (please check one box):					
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )	
Is this person a patient here?	❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )	
Is this patient covered by insurance?	❑ Yes ❑ No			
Name of primary insurance:	Subscriber's name:	Group no.:	Policy no.:	
Subscriber's name:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IF APPLYING FOR A FINANCIAL HARDSHIP DISCOUNT:

If applying for a Financial Hardship Discount, please see immunization receptionist for additional paperwork to complete and verify qualifications.

AUTHORIZATIONS AND AGREEMENTS

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I have received the Patient Financial Policies and understand that I am financially responsible for any balance. I also authorize Clermont County Public Health or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*