K. Anthony Shanbour, M.D.
Obstetrics & Gynecology

PATIENT DEMOGRAPHIC FORM

Please complete this form in order to ensure proper billing of your services.

Patient Information

Last Name: _____ First Name: _____ Today's Date: _____

Other Name: _____ Date of Birth: _____

Address (street): _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SS#:_____ Email:_____

PCP: _____ Ref. Physician (if different): _____

Address (street): _____ Address (street): _____

City, State, Zip: _____ City, State, Zip: _____

Telephone #:_____ Telephone #: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner

Employment Information

Employer:_____

Employer Address (street): _____ City, State, Zip: _____

Emp. Status: ≤ Full Time ≤ Part Time ≤ Not Employed ≤ Self-Employed ≤ Active Military

Student Status: (circle) Full Time Student Part Time Student

Emergency Contact Information

Emergency Contact: _____ Relationship to You: _____

Home Phone: _____ Alt. Phone: _____

Insurance Information

PRIMARY CARRIER:_____ Telephone #: _____

Policy Holder: _____ Relationship to Patient: _____

DOB: _____ ID#:_____ Group #:_____

Address: _____City, State, Zip: _____

SECONDARY CARRIER: _____ Telephone #: _____

Policy Holder: _____ Relationship to Patient: _____

DOB: _____ ID#:_____ Group #:_____

Address: _____City, State, Zip: _____

TERTIARY CARRIER: _____ Telephone #: _____

Policy Holder: _____ Relationship to Patient: _____

DOB: _____ ID#:_____ Group #:_____

Address: _____City, State, Zip: _____

Additional Information

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Island

☐ Asian ☐ White

☐ Black or African American ☐ Denied/ Refused to report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Denied/ Refused to Report

Preferred Language: ☐ English ☐ Spanish ☐ Other:

How did you hear about our practice? ☐ Health Plan ☐ Internet ☐ Our Web Site

☐ Newspaper/Magazine ☐ Patient_____ ☐ Other_____

LMP (Date of last menstrual period)- _____

Pharmacy Information

Pharmacy Name: _____

Address (street): _____ City, State, Zip: _____

Phone: _____ Fax: _____

Pharmacy Name: _____

Address (street): _____ City, State, Zip: _____

Phone: _____ Fax: _____

_____ _____ _____

Signature of Patient or Representative Date Time

_____

Print Name of Patient or Representative