*FORM 2* **DEMOGRAPHIC & INSURANCE INFORMATION**

Today's Date:

***DEMOGRAPHICS:***

Patient Last Name: _____
Patient First Name: _____
Middle Initial: _____
Address: _____
City: _____
State: _____ ZIP: _____
Home Phone #: _____
Daytime Phone #: _____
Cell Phone #: _____
E-mail Address: _____

Gender: Female
Date of Birth:
Social Security #:
Marital Status: Married
Employment Status: Unknown
Preferred Language: English
Race: Native Hawaiian or Pacific Islander
Ethnicity: Native Hawaiian / Pacific Island
Communication Pref: Telephone

- ◯ I will not be using health or vision insurance for today's visit. (PROCEED NO FURTHER.)
- ◯ The person listed above is the PRIMARY INSURED on their health/vision plan. (Please complete only Part 1 below.)
- ◯ The person listed above is NOT the PRIMARY INSURED on their health/vision plan. (Please complete Parts 1 & 2 below.)

***Part 1 - INSURANCE INFORMATION*** (If applicable, please allow us to make a copy of your insurance card.)

Insurance Type: Medical
Relationship to Insured? Child
Insurance Company Name: _____
Member / Insurance ID #: _____

Patient Employer: _____
Employer Address: _____
City, State & ZIP: _____
Employer Phone #: _____
Position/Occupation: _____

Are you covered by another insurance plan? No
Insurance Type: None

If YES: Insurance Company Name: _____
Member / Insurance ID #: _____

** over please **

## *Part 2 - GUARANTOR / PRIMARY INSURED INFORMATION*

Guarantor Last Name: _____ Gender: Female

Guarantor First Name: _____ Date of Birth:

Guarantor M.I.: _____ Social Security #:

Guarantor Address: _____

Guarantor City: _____

Guarantor State: _____ ZIP: _____

Home Phone #: _____

Cell/Daytime Phone #: _____

Guarantor Employer: _____ Employer Phone #: _____

Employer Address: _____

City, State & ZIP: _____