UPMC Hamot Physician Network

Demographic Form

Dear Patient,

In order for us to serve you better and ensure completeness of your information, please take a moment to provide us with the below information.

Last Name: _____ First Name: _____MI_____

Date of Birth: _____ Marital Status: _____ Sex: _____

Race: _____ Ethnicity: ☐Hispanic/Latino ☐ Non-Hispanic/Latino ☐Not specified ☐Decline

Address: _____ Social Security Number: _____ -_____-_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer Name: _____ Work Phone: _____

Email Address: _____

If Patient is a minor, please list parent or guardian name: _____

Emergency Contact:

Name: _____Relationship to patient: _____

Home Phone: _____ Cell Phone: _____

Insurance Information

Primary Insurance Company Name: _____ PCP copay $_____Spec copay $_____

Identification or Policy number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Relationship to Patient: _____ Social Security Number of policy holder: _____

Policy Holder Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance Company Name: _____ PCP copay $_____Spec copay $_____

Identification or Policy number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Relationship to Patient: _____ Social Security Number of policy holder: _____

Policy Holder Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

Revised 9/11/17