CEDAR CREEK HOSPITAL of Michigan

DEMOGRAPHIC AND INSURANCE INFORMATION

PATIENT INFORMATION (PLEASE PRINT)**:**

Legal Name: _____ Date of Birth: _____

Address: _____ Primary Phone # _____

City: _____ State: _____ Zip: _____ County: _____

Gender:_____ Marital Status: **M☐S☐W☐D☐** Race: _____ Social Security #: _____

Pharmacy Name and Number _____ Pharmacy Phone # _____

RESPONSIBLE PARTY (if patient is a minor or has a guardian) ☐ **Adult: Self-Responsible Guarantor** **Yes** ☐ **No** ☐

Legal Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Relationship to Patient: _____ Social Security #:_____

Phone – Primary #: _____ Secondary #: _____

INSURANCE INFORMATION: ☐ **Consent to speak to policy holder regarding benefit and financial information**

PRIMARY INSURANCE CO: _____ ID#: _____

Employer/Group Name: _____ Group #: _____

Policy Holder's Name: _____ Soc. Sec. #: _____

Birthdate of Insured: _____ Relation to Patient: _____

SECONDARY INS. CO: _____ ID#: _____

Employer/Group Name: _____ Group #: _____

Policy Holder's Name: _____ Soc. Sec. #: _____

Birthdate of Insured: _____ Relation to Patient: _____

PRESCRIPTION COVERAGE: _____ ID#: _____

Emergency Contact: _____ Relation To Patient:_____

Phone: _____ Alt Phone: _____
