ACCT# _____

For office use only.

Ironwood Physicians, PC

PATIENT DEMOGRAPHIC INFORMATION

Patient Information

Name: _____ DOB: _____ Marital Status: _____

Address: _____ City/Zip: _____

Social Security: _____ Is Arizona your permanent address? YES NO

Secondary Address (If applicable)

Address: _____ City/Zip: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Contact Information

Check preferred method of contact

☐ Cell: _____ OK to leave detailed voicemail? YES NO

OK to communicate via text? YES NO

☐ Home: _____ OK to leave detailed voicemail? YES NO

☐ Email: _____

OK to communicate via email (ex. appointment reminders, clinical and billing information)? YES NO

Responsible Party - Other than the patient

Name: _____ Relationship: _____

Address: _____ City/Zip: _____

Employment - Person responsible for payment

Are you currently working? YES NO Is your spouse currently working? YES NO

Are you disabled? YES NO Are you retired? YES NO

Employer Name: _____ Employer Phone: _____

Employer Address: _____ City/Zip: _____

Insurance Information

Primary Insurance: _____ Phone: _____

Insured Name: _____ DOB: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Phone: _____

Insured Name: _____ DOB: _____

Policy #: _____ Group #: _____

Patient Signature/Responsible Party: _____ Date: _____