Oscar T. Ortiz, M.D. Ronald B. Villanueva, M.D.

PATIENT DEMOGRAPHIC INFORMATION SHEET

(PLEASE PRINT CLEARLY)

Name: ____ Social Security #: ______-______-_______
(Last) (First) (Middle Initial)

Address: ____ Apt. # _____________

City: ____ State _____________________ Zip ____________________

Home Phone: (______)________-___________________Work Phone: (______)________- _______________________

Cell Phone: (______)________-______________Email Address:**____

Date of Birth: ______________________________ Sex: (M / F) Marital Status : (S / M / W / D)

In Case of Emergency Contact: ___________________________________ Phone: (_____)_______- ________________

Purpose of visit or Diagnosis: ____

Referring Physician's Name: ____Phone (_____)_____-________________

Primary Care Physician: ____ Phone (_____) _____-_________________

Pharmacy: ____ Phone (_____)______- ______________________

Employer Name: ____

PRIMARY INSURANCE	SECONDARY INSURANCE
Ins. Co. Name:____	Ins. Co. Name: _________________________________
Policy #: _______________________ Group # __________	Policy #: ____________________ Group # __________
Relationship to Patient: _____________________________	Relation to Patient: _____________________________
Insured Name : ________________________________ ___	Insured Name : _________________________________
Insured Date of Birth: _______________________ M / F	Insured Date of Birth: ______________________ M / F
Insured SS#: ______-_______-____________________ ___	Insured SS#: ______-_______-____________________

To protect patient confidentiality, we will only disclose your medical information as you instruct us to. Please answer the following:

May we leave message on your answering machine with the appointment time? _______Yes ______ No

May we leave messages on answering machine about medication changes? ________ Yes _______ No

May we call you at work? _______ Yes _________ No

What family member may we discuss your medical condition with?

Name: _________________________________ Relation: ______________________________

Name: _________________________________ Relation: ______________________________

Name: _________________________________ Relation: ______________________________

I have read the Office Policies: ____

(Sign)

I hereby authorize my insurance company benefits to be paid directly to **Oscar T. Ortiz, MD PC.** I realize I am responsible to pay any non-covered services, co-payment and co-insurance. I hereby authorize the release of pertinent medical information to the insurance company. I also realize that if my insurance plan requires referral, I am responsible to have a valid referral at every office visit. If for any reason my insurance does not cover services rendered, I am responsible for payment in a timely manner. I also authorize the provider to retrieve my medication data from Pharmacy &/or Pharmacy Benefit Manager Organizations.

____

(Signature/ Date)

**** I am granting the office to use the above email address for the patient portal _____________(initial)**

Revised 11/23/2020 mog