# Medical Demographic

**Patient's Name**_____ **Date of Birth**_____

**Address**_____ **Home Phone**_____

_____

**Cell Phone**_____ **Email**_____

**Sibling's Name** _____ **Date of Birth** _____

**Sibling's Name** _____ **Date of Birth**_____

**Mother's Name** _____ **DOB**_____

**Work Phone** _____ **Profession**_____

**Father's Name** _____ **DOB**_____

**Work Phone** _____ **Profession**_____

**Primary Insurance**_____ **Secondary Insurance**_____

**Insured Party**_____ **Insured Party**_____

**Emergency Contact:**

**Name** _____ **Phone** _____ **Relation**_____

**Who do we thank for this referral?** _____

**Assignment of Benefits and Consent for Use and Disclosure of Information:**
I. the undersigned, authorize payment of medical benefits to Marina Yam MD for any services furnished to my child I understand that I am financially responsible for charges not covered by this assignment.
I hereby give consent to my provider to use and disclose my protected health information for the purpose of treatment, payment and health care operations. Our notice of privacy practices provides more detailed information about how we may use and disclose your protected health information. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

Signature_____ Date _____

Print your name _____ Relationship to patient_____