JOHN J. BORKOWSKI, MD
PATIENT DEMOGRAPHICS

PATIENT INFORMATION:

Last Name: _____Social Security #_____

First Name: _____Middle Initial: ____Date of Birth: _____ Age: _____

Sex: Male Female Marital Status: Single Married Divorced Separated Widow(er)

Phone Numbers:

Home: (_____)_____Cell: (_____)_____Work: (_____)_____

Email: _____

Home Address

Street: _____PO Box: _____

City: _____State: _____Zip:_____

Referring Physician: _____Family Physician: _____

Patient's Employer: _____Occupation: _____

Employer's Address:

Street: _____PO Box: _____

City: _____State: _____Zip: _____

In Case of Emergency Contact:

Name: _____Phone #: (_____)_____

Pharmacy Name: _____Phone #: (_____)_____

INSURANCE INFORMATION
(Please have your insurance card available for copying)

IF YOU HAVE NO INSURANCE, CHECK HERE ☐ ****Payment is expected at the time of service.**

Primary Insurance: _____
Subscribers Name:_____
ID #: _____
Group #: _____
Co-Pay Amount: $_____

Secondary Insurance: _____
Subscriber's Name: _____
ID #: _____
Group #: _____
Co-Pay Amount: $_____

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN AND RELEASE OF INFORMATION: I hereby authorize my insurance benefits be paid directly to the physician and I am responsible for non-covered services, co-pays, deductibles and any remaining balances. I also authorize the Physician to release any information acquired in the course of my treatment to my insurance company or to my primary/referring physician in writing or by fax.

Signature: _____Date: _____