LONGWOOD UNIVERSITY

Potomac Healthcare Solutions™

Patient Demographic Form Please PRINT

Patient Name:_____
Nick Name:_____ Date of Birth:_____ Sex:_____
Address:_____
City: _____ State: _____ Zip Code:_____
Home #:_____ Cell #:_____ Work #:_____
Language (other than English):_____ Race:_____ Ethnicity:_____
Email address: _____ Employer: _____
Emergency Contact: _____ Phone #: _____
Insurance? Yes_____ No_____ PCP_____

INSURANCE INFORMATION

Ins Co Name: _____ Policy/ Member ID #:_____
Patient Relation to Insured: Self: _____ Spouse: _____ Child:_____ Other: _____
Policy Holder: _____ Sex: _____
Address: _____City: _____ Zip Code: _____
Home #:_____ Date of Birth: _____
Employer: _____

SECONDARY INSURANCE

Ins Co Name: _____ Policy/ Member ID #:_____
Patient Relation to Insured: Self: _____ Spouse: _____ Child:_____ Other: _____
Policy Holder: _____ Sex: _____
Address: _____ City: _____ Zip Code: _____
Home #: _____ Date of Birth: _____
Employer: _____

Diagnostic Testing: We recommend that you call your insurance company to be informed of your benefits for any diagnostic test that The University Health Center may order for you. You should inquire if pre-certification is needed. If so, you will need to contact our office one week prior to your scheduled procedure to avoid claim denial.

Financial Policy: To ensure accurate claim filing, please give your most current insurance card to our front office to be copied. Potomac Healthcare Solutions, LLC participates with most managed care plans. We will bill your insurance company in compliance with the guidelines of our contract. If you do not have health insurance, please indicate above. Random audits may be completed to ensure the accuracy of reported information.

I hereby authorize Potomac Healthcare Solutions, LLC to provide me with medical treatment. I understand and agree that I am responsible for all fees not covered by my insurance company. I hereby authorize the release of any medical information necessary to file a claim with my insurance company. I understand that any refusal or misrepresentation of my insurance coverage may result in a balance for services rendered.

_____ _____

Patient/Responsible party signature Date