CLOVIS E MANLEY, MD LLC
4943 Rosebud Lane
Newburgh, IN 47630

PATIENT DEMOGRAPHIC FORM **Please present your driver's license or other photo ID, most recent insurance card(s) and copay if applicable.**

Please PRINT

PATIENT INFORMATION

Last Name:_____ **First Name**:_____ **MI**:_____

Date of Birth:_____ **Social Security Number**:_____ **Gender**: ☐ Male ☐ Female

Address:_____ **City**:_____ **State**:_____ **Zip**:_____

Cell Phone #:(_____)_____ **Home Phone #**:(_____)_____ **Email Address**:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment Status: ☐ Employed Full-Time ☐ Employed Part-Time ☐ Self Employed ☐ Not Employed ☐ Disabled ☐ Retired ☐ Active Duty Military

Employer Name: _____ **Phone #**:(_____)_____ **Occupation**: _____

EMERGENCY CONTACT

Name:_____ **Phone #**:(_____)_____ **Relationship to Patient**:_____

PRIMARY INSURANCE

Insurance Name:_____ **Policy/ID #**:_____ **Effective Date**:_____

Policy Holder's Relationship to Patient: ☐ Self **(DO NOT complete shaded section below)** ☐ Spouse ☐ Parent ☐ Other **(specify)**:_____

Name of Policy Holder:_____ **DOB**:_____ **SSN #**:_____

Address (if different than the patient):_____ Phone #:(_____)_____

SECONDARY INSURANCE (if applicable)

Insurance Name:_____ **Policy/ID #**:_____ **Effective Date**:_____

Policy Holder's Relationship to Patient: ☐ Self **(DO NOT complete shaded section below)** ☐ Spouse ☐ Parent ☐ Other **(specify)**:_____

Name of Policy Holder:_____ **DOB**:_____ **SSN #**:_____

Address (if different than the patient):_____ Phone #:(_____)_____

I certify the above information is correct to the best of my knowledge.

Signature:_____ **Date**: _____