118 Third Street Southeast • Huron, South Dakota 57350
Phone: 605.352.2117 • Fax: 605.554.2200

New Life Clinic
Patient Demographic Form

Patient Information:

Name (First, MI, Last): _____

Date of Birth _____ Social Security Number: _____-_____-_____

Sex: M ____ F ____ Marital Status: S ____ M ____ D ____ W ____ Race: _____

Language Preference if not English: _____

Street Address: _____ Apt. No.: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone or Pager: _____

Email Address: _____

Emergency Contact Name: _____ Emergency Contact Number: _____

Responsible Party Information:

Name (First, MI, Last): _____

Relationship to Patient: _____ Date of Birth: _____

Social Security Number: _____-_____-_____ Race: _____ Marital Status: _____

Address: _____ Apt. No.: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone or Pager: _____

Employer's Name: _____ Work Phone: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance Company's Name: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Insurance Phone Number: _____

Name of Policy Holder: _____ Date of Birth: _____

Insurance ID Number: _____ Group Number: _____

Secondary Insurance Company's Name: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Insurance Phone Number: _____

Name of Policy Holder: _____ Date of Birth: _____

Insurance ID Number: _____ Group Number: _____

Please Read and Sign this Form: I hereby authorize my insurance benefits to be paid directly to New Life Family Medicine. I understand and am responsible for all charges including the added costs required for collection services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

What pharmacy do you use? _____