Benson Area Medical Center
A Caring Touch For All Ages – Since 1979

Demographics Form

( ) **Mr.** ( ) **Mrs.** ( ) **Ms.** ( ) **Dr.**

Last Name _____ **First Name** _____ **Middle** _____

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

Marital Status: ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed ( ) Declined

Race: ( ) American Indian or Alaska Native ( ) Asian ( ) Black or African American ( ) White
( ) Native Hawaiian or Other Pacific Islander ( ) Other Race ( ) Declined

Ethnicity: ( ) Hispanic or Latino ( ) Non-Hispanic or Latino ( ) Declined

Preferred Language: ( ) English ( ) Spanish ( ) Other, specify _____

Address _____

City _____ **State** _____ **ZIP** _____

Phone, check best phone to contact: ( )Home _____ - _____ - _____ ( )Cell _____ - _____ - _____
( )Work _____ - _____ - _____ ext.____
Email _____

Policy Holder Name _____ **Relationship to Patient**_____

Policy Holder's Date of Birth _____

Emergency Contact _____ **Relationship to Patient** _____

Phone _____ - _____ - _____

Your Benson Area Medical Center Provider (who do you see?) _____

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT: I authorize treatment of the person named above. I authorize the release of any medical information necessary to process insurance claims. I request payment to government benefits or other insurance agency benefits to be made to the Physicians or facility for services performed. It is agreed that if payment is not made by insurance, I will be held liable (this includes lack of payment due to insurance deductibles, lapse of coverage, or preexisting conditions). Notice: DO NOT sign this agreement before you have read and agree with the conditions set forth above.

Signature _____**Date** _____

This institution is an equal opportunity provider and employer.