Dr. Cheryl A. Duffy, MD, FAAP, Inc.
Patient Demographic Sheet
Please complete in entirety

Patient Information:

Patient Name: ______________________________ D.O.B. ____________
Sex: M / F   Social Security #: _____-_____-_______
Address: ____
Home Phone #: (____) ____-_______
Siblings: ____

Responsible Party Information:

Mother's Name: ______________________________ D.O.B. ____________
Address: ____
Social Security #: _____-_____-_______
Home Phone #: (____)_____-______ Work Phone #: (____)_____-_____
Father's Name: ______________________________ D.O.B
Address: ____
Social Security #: _____-_____-_______
Home Phone #: (____)_____-______ Work Phone #: (____)_____-_____

Emergency Contact (other than parent)

Name: __________________________ Relationship: ____________________
Address: ____
Phone: (_____)_____-_______

Insurance Information:

Primary Insurance Name: ____
Address: ____
Phone #: (_____)_____-_______
Policy Holder's Name: ______________________ Effective Date: _______
Policy #: _________________________________ Group #: ______________
Employer: _____________________________________ Copay $: _______

Secondary Insurance Name: ____
Address: ____
Phone #: (_____)_____-_______
Policy Holder's Name: _______________________ Effective Date: ______
Policy #: _________________________________ Group #: ______________
Employer: _____________________________________ Copay $: ________

I authorize the release of any medical or other information necessary to process this claim. I also request payment of Government or Insurance benefits either to myself or the party who accepts assignment below. I also authorize payment of medical benefits to the undersigned physician or supplier for services described herein. I also understand I am financially responsible for all charges not covered by this authorization and guarantee payment on this account.

Signed: ____ Date: __________

It is the responsibility of the patient to notify the office of any and all insurance changes. If complete billing information is not available at the time of service, the claim will be made self pay until information is provided.