ANDREA DEMPSEY, M.D.
7170 Smoke Ranch Rd Suite 110 Las Vegas NV 89128
PHONE (702) 463-3333 FAX (702) 541-6081

PATIENT INFORMATION

LAST NAME: MI: FIRST:

DOB: GENDER (circle one): M F MARITAL STATUS (circle one): S M D W

RACE (circle one): American Indian and Alaskan Native; Asian; Black or African American; Black Hispanic or Latino; Native Hawaiian and Other Pacific Decent; White; White Hispanic or Latino; Refuse to answer

Ethnicity (circle one): Hispanic or Latino; Not Hispanic or Latino; Refuse to answer
Language Preference (circle one): English; Chinese; French; German; Italian; Japanese; Korean; Portuguese; Spanish; Refuse to answer

HOME PH # CELL PHONE #

STREET APT# CITY STATE ZIP

EMAIL ADDRESS:

SS # :

GUARANTOR:

LAST NAME: MI: FIRST:

SS# DOB PHONE #:

STREET CITY STATE ZIP

EMPLOYER PHONE #:

STREET CITY STATE ZIP

EMERGENCY CONTACT:

NAME PHONE CELL PHONE

RELATIONSHIP

NAME PHONE CELL PHONE

RELATIONSHIP

INSURANCE INFORMATION

PRIMARY INSURANCE:

ADDRESS: CITY: STATE:

POLICY HOLDER NAME: DOB

SS# RELATIONSHIP TO PATIENT:

POLICY HOLDER EMPLOYER:

POLICY # GROUP # DATE EFFECTIVE:

SECONDARY INSURANCE:

ADDRESS CITY: STATE: ZIP:

POLICY HOLDER NAME: DOB:

SS# RELATIONSHIP TO PATIENT:

POLICY HOLDER EMPLOYER:

POLICY # GROUP # DATE EFFECTIVE:

The above information is complete and correct. I authorize treatment for the above patient. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor indicated on the claim. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that be may added to my account in order to recover monies due to the doctor.

PATIENT SIGNATURE (above line) DATE GUARANTOR SIGNATURE DATE

All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage.