Rowan University
School of Osteopathic Medicine

New Demographic Patient Form

Date	
Patient Signature	
Last Name, First Name	
Address Line 1 **Address Line 2** **City, State Zip**	
Home Phone Number	
Cell Phone	
Social Security Number	
Date of Birth	
Sex	☐ Male ☐ Female ☐ Indeterminate
Marital Status	☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Ethnicity	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unreported or Refused to report
Preferred Language	☐ English ☐ Spanish ☐ Other _____
Race	☐ Other _____ ☐ Asian ☐ Black/African American ☐ Black Hispanic ☐ Chinese ☐ Filipino ☐ Hispanic Latino ☐ Japanese ☐ More than one race ☐ Multi-Racial ☐ White ☐ White Hispanic ☐ Indeterminate
Employer	

Employer Address Line 1	
Employer Address Line 2	
City, State Zip	
Work Phone Number	
Email Address	
Emergency Contact	
Emergency Contact Phone #	
Primary Care Physician Name	
Special Needs	☐ Hearing Impaired ☐ Interpreter ☐ Sight Impaired ☐ Sign Language Interpreter ☐ Transportation Needs ☐ Wheelchair
Relationship to Guarantor	☐ Dependent Child ☐ Foster Child ☐ Grand Child ☐ Nephew ☐ Niece ☐ Other ☐ Self ☐ Spouse ☐ Step Child ☐ Student
Guarantor Name	
Guarantor Address Line 1 **Guarantor Address Line 2** **Guarantor City, State Zip**	
Guarantor Home Phone #	
Guarantor Social Security #	
Guarantor Date of Birth	
Guarantor Sex	☐ Male

	☐ Female ☐ Indeterminate
Guarantor Employer	
Guarantor Employer Add Line 1 **Guarantor Employer Add Line 2** **Guarantor City, State Zip**	
Guarantor Work Phone #	
Contact Name 1	
Contact Type 1	☐ Agency ☐ Neighbor ☐ Other ☐ Parent/Guardian ☐ Relative
Relationship to Contact 1	☐ Dependent Child ☐ Foster Child ☐ Grand Child ☐ Nephew ☐ Niece ☐ Other ☐ Self ☐ Spouse ☐ Step Child ☐ Student
Primary Insurance Company Name	
Ins. Company Address Line 1 **Ins. Company Address Line 2** **Ins. Company City, State Zip**	
Ins. Company Phone #	
Certificate Number	
Group Number	
Plan Number	
Primary Copay	
Specialty Copay	

Relationship to Subscriber	☐ Dependent Child ☐ Foster Child ☐ Grand Child ☐ Nephew ☐ Niece ☐ Other ☐ Self ☐ Spouse ☐ Step Child ☐ Student
Secondary Insurance Company Name	
Ins. Company Address Line 1 **Ins. Company Address Line 2** **Ins. Company City, State Zip**	
Ins. Company Phone #	
Certificate Number	
Group Number	
Plan Number	
Primary Copay	
Specialty Copay	
Relationship to Subscriber	☐ Dependent Child ☐ Foster Child ☐ Grand Child ☐ Nephew ☐ Niece ☐ Other ☐ Self ☐ Spouse ☐ Step Child ☐ Student
RowanSOM Authorization	I hereby authorize RowanSOM Department of _____ to Release any information acquired in the course of medical examination or treatment for insurance claim filing. I authorize any holder of my medical information to release to the Healthcare Financing Administration and its agent any information needed to determine these benefits payable to related services. Photostat of this

	authorization shall be considered as effective & valid as the original Initial____ Date_____ The insurance information listed is accurate & in the correct order Initial____ Date_____ I certify that service(s) covered by this claim have been received & I request payment be made on my behalf to RowanSOM Department of 2_____ for any services furnished to me by that physician group Initial____ Date_____ I understand that I am responsible to know the details of my policy including what services will not be covered. By signing below, I acknowledge that I will be personally responsible for payment for the services I elect to have rendered. I acknowledge that I have received a copy of the RowanSOM Notification of Patient's Privacy Practices. _____ Signature of Patient/Legal Representative and Relationship Date.