Oklahoma Medical Research Foundation
Multiple Sclerosis Center of Excellence
825 NE 13th Street
Oklahoma City, OK 73104
405-271-6242
Fax 405-271-2887
omrf.org/MS Center

PATIENT DEMOGRAPHICS
(Please use legal name)
PLEASE PRINT CLEARLY

Name of Patient _____ Birth Date _____/_____/_____
(Last) (First) (MI)

Age: _____ Marital Status: _____ Gender: ____Male ____Female Social Security #: _____/_____/_____

Occupation: _____

Ethnicity (circle all that apply):
_____ Hispanic/Latino (Cuban, Mexican, Puerto Rican, South or Central American, or Spanish culture or origin, regardless of race.)
_____ Non Hispanic/Latino

Race:
_____ American Indian or Alaska Native
_____ Asian
_____ Black or African American
_____ Native Hawaiian or Other Pacific Islander
_____ White

Home Address: _____
(Street) (City) (State) (Zip)

Mailing Address: _____
(Street) (City) (State) (Zip)

Cell Phone #: (_____)_____ Home Phone #: (_____)_____

E-mail address: _____Language: _____ Interpreter Needed? _____

Employer: _____ Work Phone #: (_____)_____ Ext. _____

Emergency Contact Name: _____ Home Phone #: (_____)_____

Relationship to Patient: _____ Cell Phone #: (_____)_____

Referring Physician: _____ Phone #: (_____)_____

Primary Care Physician: _____ Phone #:(_____)_____

Address: _____
City State Zip

Have you obtained insurance coverage through the Affordable Care Act Marketplace? ____ Yes* ____No
***NOTE**: If you answer YES to this question, please be aware that you must provide proof of current premium payments at **EACH** appointment.

Insurance Information: ***We will need a copy of your insurance card in order to file a claim.***

Primary Insurance Coverage: _____ Policy #: _____

Group #: _____ Insured's Name: _____

_____Male _____Female DOB: _____ SSN: _____

Relationship to Patient: _____ Primary Insured's Employer: _____

(Please complete back of form)

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Secondary Insurance Coverage: _____ **Policy #:** _____

Group #: _____ Insured's Name: _____

_____Male _____Female DOB: _____ SSN: _____

Relationship to Patient: _____ Primary Insured's Employer: _____

Guarantor Name: _____ Address: _____ Phone: (____)_____
City State Zip

Family Members:

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Patient/Signature:
I hearby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtrain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled, to this practice. I understand that payment is due at the time of service and that I am financially responsible for all charges, whether or not paid by insurance.

Signature: _____ Date: _____/_____/_____

(Rev. 9/2019 ts)