

St. Louis Hills Internal Medicine  
6901 Chippewa Street  
Saint Louis, MO 63109  
Phone: (314) 644-7000  
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Patrick H. Durbin, MD  
April Brumley, FNP-C

### PATIENT DEMOGRAPHIC DATA

PATIENT: \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)

ADDRESS: \_\_\_\_\_  
(Street Number and Name) (City & State) (Zip Code)

HOME PHONE #: \_\_\_\_\_ CELL PHONE #: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_ EXT: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ GENDER: M F \_\_\_\_\_ MARITAL STATUS: D W M S

SOCIAL SECURITY #: \_\_\_\_\_ PATIENT'S EMPLOYER: \_\_\_\_\_

STUDENT STATUS: FULL PART N/A EMPLOYEE STATUS: FULL TIME PART TIME RETIRED UNEMPLOYED

EMERGENCY CONTACT NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_ REL. TO PT.: \_\_\_\_\_

LOCAL PHARMACY NAME: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

MAIL PHARMACY NAME: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

PREFERRED LANGUAGE: \_\_\_\_\_ ETHNICITY: HISPANIC/LATINO NON-HISPANIC/LATINO REFUSED

E-MAIL ADDRESS: \_\_\_\_\_ *Inquire About our Patient Portal at the Front Office*

### FINANCIAL RESPONSIBILITY DATA

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SS #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(Street Number and Name) (City & State) (Zip Code)

### PRIMARY INSURANCE DATA

PRIMARY INSURANCE: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

NAME OF INSURED/SUBSCRIBER: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

INSURED'S DATE OF BIRTH: \_\_\_\_\_ I.D. #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

INSURED'S SSN: \_\_\_\_\_ INSURED'S HOME ADDRESS: \_\_\_\_\_

INSURED'S TELEPHONE #: \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

**SECONDARY INSURANCE DATA**

SECONDARY INSURANCE: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

NAME OF INSURED/SUBSCRIBER: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

INSURED'S DATE OF BIRTH: \_\_\_\_\_ I.D. # : \_\_\_\_\_ GROUP # : \_\_\_\_\_

INSURED'S SSN: \_\_\_\_\_ INSURED'S HOME ADDRESS: \_\_\_\_\_

INSURED'S TELEPHONE #: \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

**ASSIGNMENT OF INSURANCE INFORMATION AND BENEFITS  
RELEASE OF MEDICAL INFORMATION RELATED TO MY CARE**

I authorize my St. Louis Hills Internal Medicine practitioner to administer any medical or surgical procedure considered necessary and authorize the release of related information as required to request and secure payment. I authorize benefits paid by my insurance company to be paid directly to Patrick H Durbin MD PC, and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance companie(s). I also authorize the release of all appropriate medical information including but not limited to all medical records and diagnostic testing results to designated attending, referral, and/or follow-up physicians in addition to other health care practitioners or organizations which may provide subsequent monitoring of care and/or treatments related to the care provided by St. Louis Hills Internal Medicine.

**SIGNATURE OF RESPONSIBLE PARTY:** \_\_\_\_\_ **DATE:** \_\_\_\_\_