



Demographic Sheet

In order to maintain our records with your current information, **please complete and return this form.**

Medical Practice Group Name _____

Medical Practice Website _____

Physician Name _____ Specialty _____

Physician Date of Birth _____ Tax ID# _____

Group NPI # _____ Individual NPI# _____

CAQH# _____ Medical License # _____ DEA# _____

Group Medicare# _____ Individual Medicare# _____

Group Medicaid# _____ Individual Medicaid# _____

Group BC/BS# _____ Individual BC/BS# _____

Admitting Hospitals _____

Primary Office Address _____

_____ County _____

Office Phone _____ Office Fax _____

Physician Email _____ Physician Mobile Phone _____

Additional Office Address _____

Additional Office Phone _____ Additional Office Fax _____

Office Manager/ Office Contact _____ Phone _____

Office Manager/Office Contact Email _____

EMR/Practice Management System _____

Nurse Manager/Clinical Contact _____ Phone _____

Nurse Manager/Clinical Contact Email _____

Physician's signature: _____ **Date:** _____