Northern Light Health℠

Patient Demographics Form

Northern Light Primary Care, University of Maine
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primarycareumaine@northernlight.org
Questions related to insurance referrals should be directed to 207.581.4006.

PATIENT/STUDENT INFORMATION

Name: ______________________________ SS#: ______________ DOB: ______________
Last First MI

Preferred Name: ____________________ Race: ____________ Religion: ______________

Birth sex: [ ] Female [ ] Male [ ] Unknown [ ] Unspecified Gender identity: [ ] Female [ ] Male [ ] Unknown [ ] Unspecified

Home Address: ____
City/State Zip

Home Phone: ____________________ Cell Phone: ____________________

EMERGENCY CONTACT INFORMATION

Name: ______________________ Relationship to Student: ______________
Last First MI

Home Address: ____
City/State Zip

Home Phone: ____________________ Cell Phone: ____________________

INSURANCE PLAN INFORMATION (we must have the policyholder's address and DOB in order to bill your plan)

Insurance Company: ____________________ Phone Number: ____________________

Address: ____
City/State Zip

Policy/Certificate #: ______________ Group #: ______________ Copay: ______________

Policyholder's relationship to student: ☐ Parent ☐ Guardian ☐ Self

Policyholder's Employer: ____________________ Employer Phone: ______________

Employer Address: ____
City/State Zip

Policyholder: ______________________ SS#: ______________ DOB: ______________
Last First MI

Home Address: ____
City/State Zip

Home Phone: ____________________ Cell Phone: ____________________

PRIMARY CARE PROVIDER/DOCTOR INFORMATION

Name: ______________________ Phone Number: ______________________

Address: ____
City/State Zip

REFERRAL SCREENING – PLEASE CONTACT YOUR INSURANCE AND ASK THE FOLLOWING QUESTIONS

☐ If you live outside of Maine, does your insurance plan have out-of-state coverage [ ] YES [ ] NO (*)
☐ Does your insurance plan have out of network coverage [ ] YES [ ] NO (*)
☐ Does your insurance plan require a referral to be seen at Northern Light Primary Care, UMaine (Tax ID # 01-1211501) [ ] YES [ ] NO

*** If you answered NO to numbers 1&2, please be aware that you may be responsible for all charges incured during your visit. You may want to consider purchasing the University's student health insurance plan.**

Please include a copy of the front and back of your insurance card(s) – please use the self addressed stamped envelope to return this form to our office. To add additional insurance information please provide a 2nd copy.

For Office Use Only: *Entered On:* ______________ *Initials:* ______________