Timothy O. Wahl, M.D., FACP
Sarah B. Konigsberg, M.D. **Umasankari Sundaram, M.D.**
Claire H. Baker, M.D., FACE **Radha Andukuri, M.D.**

Patient Demographic Form

_________________________ ______ ______________________________ _____/_____/ __________
Legal Name First MI Last Date Of Birth

___________________________________ ___________________ _______ ____________
Address City State Zip Code

(____) ______-________ (____) ______-________ (____) ______-________ ______________________________
Home Phone Cell Phone Work Phone E-mail address

Gender ______________________ Marital Status ____________________________ SS Number________ - _____ - ____________

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to report

Race: ☐White ☐Black or African American ☐ American Indian or Alaska Native ☐Asian ☐Pacific Islander ☐Native Hawaiian ☐More than one race ☐Refuse to report

Language: Is English your primary language ☐Yes ☐No If no, please list ______________________________

____________________________ __________________________ (_____) _________-____________
Emergency Contact Name Relationship Emergency Contact Number

___________________________________ _________________________________
Primary Care Physician Referring Physician

:: :::

_______________________ ____________________________ ________________________
PRIMARY Insurance Company ID / Member Number Group Number

_______________________________________ ________ - _____ - ____________ _____/_____/ ____________
Name of Policy Holder Policy Holder's SSN Date Of Birth

_______________________ ____________________________ ________________________
SECONDARY Insurance Company ID / Member Number Group Number

_______________________________________ ________ - _____ - ____________ _____/_____/ ____________
Name of Policy Holder Policy Holder's SSN Date Of Birth

I, the undersigned, give permission to treat and assign directly to Diabetes & Endocrine Associates, P.C., all medical benefits, if any, otherwise payable to me for services rendered. I also understand that I am financially responsible for all charges not paid by my health benefits provider. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and authorize the use of this signature (or copy thereof) to provide necessary medical information to my insurance carrier upon their request.

____ _______/ _______/ ___________
Signature Date

7831 Chicago Court Omaha, NE 68131
(402) 561-2740 (402) 561-2738