Providing Primary Care to Adult Men and Women

Demographic Information

PATIENT PERSONAL INFORMATION FORM

Patient Name: ______________________________

Gender: __________ Date of Birth: ______________ Marital Status: ______________

Social Security #: ______________ Driver License #: ______________

Street Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Home Phone #: ______________ Cell Phone #: ______________

How Did You Hear About Us: ______________ E-mail Address: ______________

Employer Information

Employer Name: ______________________________

Employer Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Work Phone#: ______________ Position: ______________

Emergency Information

Contact Name: ______________ Relationship: ______________ Phone #: ______________

City: ______________ State: ______________ Zip Code: ______________

Insurance Information

Insurance Company (**Primary**): ______________ Phone #: ______________

Claims Mailing Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Policy # : ______________ Group #: ______________

Name of Primary Insured: ______________________________

Primary Insured Date of Birth: ______________ Social Security #: ______________

Insurance Company (**Secondary**): ______________ Phone #: ______________

Claims Mailing Address: ______________________________

Policy # : ______________ Name of Secondary Insured: ______________ DOB: __________

Group #: ______________

Authorization to Release Information and Assignment of Benefits

□ By checking the box on the left, I certify that information I have reported about my insurance is correct.

□ By checking the box on the left, I authorize the release of any medical information necessary to process my insurance claims.

□ By checking the box on the left, I authorize my doctor to apply for benefits on my behalf for covered services rendered by him or her, or by his or her order. I request that payment be made directly to my doctor or to the party who accepts assignment.

□ By checking the box on the left, I acknowledge that any insurance billing done is at the discretion of my doctor. I understand that any co-pays, co-insurances and deductions deemed my responsibility are payable in full by me.

□ By checking the box on the left, I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing by either me or my insurance company.

Signature of Patient/Guardian: ____ Date: __________________