PLEASE BRING YOUR INSURANCE CARDS TO ALL APPOINTMENTS

Patient Name:____ Sex: M F

Mailing Address:___________________________________ City__________________ State______ Zip__________

Home Phone # (____)__________________ Work # (____)__________________ Cell # (____)____________________

Date of Birth ______/_______/________ Age _______ Social Security #_____________________________________

Marital Status: Single ____ Married____ Widowed_____ Divorced____ Other:_____________________________

Ethnicity: _____ Hispanic or Latino _______ Non-Hispanic or Latino ______ Decline

Race: _____ American Indian or Alaskan Native _____ Asian ______ Black/African American
_____ Native Hawaiian or Pacific Islander _____ White ______ Decline

Preferred Language:__________________________

Preferred method of contact: Phone _____ E-mail _____ Mail _____

Patient's E-mail address ____

Do you approve of healthcare providers sending appointment reminders, lab results, etc. to this e-mail address?
YES ________ NO__________

Preferred Pharmacy ____

PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST

Primary Insurance Coverage with:__________________ Policy Holder______________________________
Policy Holder DOB: ______________

Secondary Insurance Coverage with:________________________ Policyholder________________________________
Policy Holder DOB: ______________

Patient's Employer (if not applicable, insert "n/a") ____

Spouse or Parent's Name ____ Date of Birth____/____/_____

Spouse/Parent's Employer________________________________ Social Security # ____________________________

Nearest Relative/Friend NOT living with you ____________________________ Phone # (_____)__________________

Were you referred to our practice by another physician? YES ________ NO _________
If so, who? ____

ASSIGNMENT OF BENEFITS
I request payments by Medicare, Medicaid, medical insurance companies and other third party payers be made payable to my healthcare providers. I authorize my physicians and healthcare providers to release my Protected Health Information (PHI) to the Healthcare Financing Administration, insurance companies, and other providers of medical services as may be necessary to provide for my clinical care and/or to determine my financial benefits or coverages, in compliance with HIPAA and other applicable laws. I hereby acknowledge I have received a Notice of Privacy Practices. I understand and agree I am responsible for any charges not paid for by my insurance.

Name of Patient or Legal Guardian (Please Print):____

Signature of Patient or Legal Guardian:____Date:_________________

Left Blank Intentionally