

PATIENT INFORMATION

Name: _____
Mailing Address: _____
City, State, Zip: _____
Home Phone: _____
Work Phone: _____
Mobile/Pager Phone: _____

Patient ID #: _____ Sex: []M []F
Date of Birth: _____ Age: _____
Social Security #: _____
Marital Status: []Married []Single []Divorced [] Other
Email: _____
Referral Source: _____
Preferred Pharmacy: _____

PATIENT EMPLOYMENT INFORMATION

[]Employed []Retired []Unemployed []Other
Employer's Name: _____
Employer's Phone: _____
Occupation: _____

EMERGENCY CONTACTS

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____

RESPONSIBLE PARTY (if patient is under 18 years of age)

Name: _____ []M []F
Address: _____
City, State, Zip: _____

Employer: _____
Home Phone: _____
Work Phone: _____
SSN: _____
Date of Birth: _____

PRIMARY INSURANCE

Insurance Company Name: _____
ID #: _____
Group/Policy #: _____
Subscriber's Name: _____ []M []F
Subscriber's Phone #: _____
Relationship to Insured: _____
Subscriber's Employer: _____
Subscriber's SS #: _____
Subscriber's Date of Birth: _____

SECONDARY INSURANCE

Insurance Company Name: _____
ID #: _____
Group/Policy #: _____
Subscriber's Name: _____ []M []F
Subscriber's Phone #: _____
Relationship to Insured: _____
Subscriber's Employer: _____
Subscriber's SS #: _____
Subscriber's Date of Birth: _____

Is there anyone else we can speak to regarding this account? []Billing []Medical []Scheduling

_____	_____	_____
Name	Relationship	Date of Birth
_____	_____	_____
Name	Relationship	Date of Birth

INSURANCE AUTHORIZATION AND ASSIGNMENT

(Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to Medical Park Family Care, and authorize the clinic to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for any amount not paid for by my insurance.***

PATIENT/GUARDIAN SIGNATURE

DATE