Family Medicine Specialists, P. C.

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PATIENT INFORMATION

(Please Print-Fill in All Blanks)

PATIENTS LEGAL NAME: LAST FIRST Middle Initial	SEX	BIRTHDATE:	AGE:

SOCIAL SECURITY NO:	MARITAL STATUS: Single Married Widowed Divorced Separated

SPOUSE'S LEGAL NAME:

PATIENTS ADDRESS:

CITY:	STATE:	ZIP CODE:

HOME PHONE: ( )	WORK PHONE:	CELL PHONE:	Are You: Employed Full-Time Student Part-Time Student Retired

INSURANCE INFORMATION - We will need a copy of the Insurance Card in order to file a claim.

Name of the Primary Insurance Carrier ______________________________

Name of the Person who carries the Insurance Policy ______________________________

Carriers DOB ______________ Carriers SS# ______________________________

Carriers Employer ______________________________

Secondary Insurance ______________________________

Carrier Name ______________________________ Relationship to Patient ______________

Not Applicable Carriers DOB ______________________________ Carriers SS# ______________

Carriers Employer ______________________________

EMPLOYMENT INFORMATION

N/A Patients Employer ______________________________ Telephone# ______________

N/A Insured Employer ______________________________ Telephone# ______________

N/A **If the patient is a minor, please list both parents names, birthdates, and employer**

Mother ______________ Birthdate ______________ Employer ______________ Telephone ______________

Father ______________ Birthdate ______________ Employer ______________ Telephone ______________

NEXT-OF- KIN INFORMATION

NEAREST RELATIVE (OR FRIEND, NOT SPOUSE) NOT LIVING WITH YOU	**BIRTHDATE**

HOME PHONE: ( )	RELATIONSHIP TO THE PATIENT:

WHO REFERRED YOU TO OUR OFFICE?

Newspaper Family Friend Phone Book Insurance Co. Magazine Employer Neighbor Other

PATIENT'S PHARMACY:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to: Family Medicine Specialists. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

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Signature **Date**