

Capital Family Practice

Patient Information (please print and answer each blank)

Patient Name: _____ Hm phone: _____

Address: _____ Apt. #: _____ City: _____ St.: _____ Zip: _____

Employer: _____ Occupation: _____ Wk. phone: _____

Cell #/Pager/Alternative #: _____

D.O.B.: _____ Social Security #: _____

Sex: ___M___F Marital Status: ___Single___Married___Separated___Divorced

Emergency Contact: _____ Relationship: _____ Phone: _____

Alt. Emergency Contact (does not reside at your home): _____

Phone: _____ Relationship: _____

Who referred you to our clinic?: _____

Do you have any drug allergies?: _____

Insurance Information

Person responsible for account: _____ Relation to patient: _____

Social Security #: _____ D.O.B. _____ Phone: _____

Address: _____ Apt. #: _____ City: _____ St.: _____ Zip: _____

Person responsible employer: _____ Occupation: _____

Work address _____ Work phone: _____

Insurance Co.: _____ Group #: _____

Subscriber #: _____ Dependant Coverage?: _____

Insurance Card and Driver's License (attach copies)

COPY OF DRIVER'S LISENCE OR PHOTO ID	Copy of insurance or:
	IF YOUR INSURANCE CARD IS NOT AVAILABLE PLEASE COMPLETE THE FOLLOWING: Policy Holder Name: _____ Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Policy Holder Social Security#: _____ Policy Holder Employer: _____ Group #: _____ Effective Date: _____ Insurance Phone #: _____ Insurance Address: _____ _____ <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Other Primary Care Physician: _____ Co-Pay: _____ Deductible: _____ Verified by: _____ Date: _____

PAYMENT IS DUE AT TIME OF SERVICE

I REQUEST AND AUTHORIZE THE DOCTORS AND STAFF AT CAPITAL FAMILY PRACTICE TO CARE FOR MYSELF AND FAMILY. I AGREE TO PHYSICIAN'S ASSISTANTS AND NURSES ASSISTING IN PATIENT CARE UNDER THE DOCTOR'S SUPERVISION. I AGREE TO BE RESPONSIBLE FOR SERVICES RENDERED.

SIGNATURE: _____ DATE: _____