PATIENT INFORMATION

Please Check One: ☐ New Patient ☐ Updated Info

Name	Social Security No.	Marital Status ☐ S ☐ M ☐ D ☐ W	Sex ☐M ☐F	Birthdate

Mailing Address	City/State/Zip	Home Phone	Cell phone # REQUIRED

Patient Employer	Employer's Address (Include City, State, and Zip)	Work Phone	Occupation

Emergency Contact (Give name, relationship, and phone number)	Race	Ethnicity

EMAIL ADDRESS

RESPONSIBLE PARTY/GUARANTOR INFORMATION

Complete this section only if the patient is NOT Responsible for this account. PARENT/ SPOUSE

Name	Sex ☐ M ☐ F	Relationship to Patient ☐Spouse ☐Child ☐Other	Birthdate

Address	City, State, Zip	Home Phone	Social Security No.

Employer	Employer's Address (Include City, State, and Zip)	Work Phone	Driver's License

INSURANCE INFORMATION COMPLETE

Please present insurance cards to Receptionist in addition to completing the area below.

INSURANCE: Company Name	Identification Number	Group Number

Insurance Company Address (Include City, State, and Zip)

Name of Policyholder (If not patient or guarantor)	Date of Birth	Relationship to policyholder

ADDITIONAL INSURANCE: Company Name	Identification Number	Group Number

Insurance Company Address (Include City, State, and Zip) Name of Policyholder (if not patient or guarantor) Date of Birth:

Medicare/Medicaid Number		

IF CORRECT INFORMATION IS NOT PROVIDED INSURANCE MAY DENY CLAIM

ADDITIONAL INFORMATION

Were you injured on the job? ☐ Yes ☐ No If yes, date of injury _____/ _____/ _____

Were you injured in an automobile accident? ☐ Yes ☐ No If yes, date of injury _____/ _____/ _____

When did you first consult us for this condition? Date _____/ _____/ _____

I request that payment of authorized insurance benefits be made on my behalf to the provider indicated above for any services furnished to me while I am a patient of Calallen Medical Clinic. I authorize any holder of medical information about me or my dependent to release to the insurance company any information needed to determine these benefits of the benefits payable for related services. A photocopy of the assignment is to be considered as valid as the original until revoked. I understand that I am financially responsible for all changes whether or not covered by said insurance.

_____/_____/_____

PATIENT/GUARANTOR SIGNATURE DATE

How did you hear about us?

☐ Phone Book ☐Newspaper (which one)_____

☐ Post Card ☐ Driving by ☐ Friend /Relative (name) _____

☐Other (please explain) _____