PATIENT INFORMATION: DATE: _____

Name: (Last, First, M.I.) _____ Date of Birth: ____/____/____

Address: _____ Apt/Unit: _____

City, State & Zip: _____

Telephone Number: (Home) _____ (Work) _____ (Cell) _____

Email Address: _____ Social Security #: _____

Person to contact in case of emergency, Name: _____ Phone #: _____

Patient Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other

Race: ☐ White ☐ Asian ☐ Hispanic ☐ African-American ☐ American Indian ☐ Other ☐ Refused

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Preferred Language: _____

Pharmacy: _____ City and Cross Streets: _____

Employers Name: _____

Employment Status: ☐ Full Time ☐ Part-time ☐ Retired ☐ Not Employed ☐ Student Full-Time ☐ Student Part-Time

Primary Care Physician: _____ Referred by: _____

INSURANCE INFORMATION: (Please provide your insurance card and driver's license to receptionist at check in)

☐ I DO NOT HAVE MEDICAL INSURANCE AND WILL BE CASH PAY

PRIMARY Insurance Company: _____

Insurance Address: _____

Subscriber's Name: _____

Subscriber's Address: _____

_____

Relationship to Patient: _____

Subscriber's Employer: _____

Subscriber's Birth Date: ____/____/____

Subscriber's Gender: ☐ Male ☐ Female

POLICY #: _____

GROUP #: _____

Effective Date: _____

SECONDARY Insurance Company: _____

Insurance Address: _____

Subscriber's Name: _____

Subscriber's Address: _____

_____

Relationship to Patient: _____

Subscriber's Employer: _____

Subscriber's Birth Date: ____/____/____

Subscriber's Gender: ☐ Male ☐ Female

POLICY #: _____

GROUP #: _____

Effective Date: _____

Please Initial _____ **I attest that I am not covered under any other health insurance and/or that I have assigned the proper responsibility to all my health insurance carriers at the time services are rendered.**

ASSIGNMENT AND RELEASE:

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I also authorize the physician to release any information required to process the claim. I agree that this office may release records pertaining to my treatment including HIV and communicable diseases to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I understand the physicians in this office are independent corporations, not in association with one another. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGNED: _____ DATE: ____/____/____