Family Medical Centers

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Account # ______________

Date: ______________

Patient Name: Date of Birth: Sex: Marital Status:

Address: City: State: Zip:

Home Phone #: Cell#: Social Security #:

Email Address:

Driver License Number: State of License:

Employer's Name & Address:

Employer's Phone #: Referring Physician:

If Patient is a Minor Please Complete This Section:

Father's Name: Social Security Number: Date of Birth:

Father's Employer: Employer's Phone #:

Father's Employer's Address:

Mother's Name: Social Security Number: Date of Birth:

Mother's Employer: Employer's Phone #:

Mother's Employer's Address:

If Patient is Married Please Complete This Section:

Spouse's Name: Social Security Number: Date of Birth:

Spouse's Employer: Employer's Phone #:

Spouse's Employer's Address:

Does the patient have health insurance? ______ Yes ______ No

If your response was yes, please list the insurance company's names. Please have your insurance cards available to copy.

Primary Insurance Carrier: ______________________________

Secondary Insurance Carrier(s): ______________________________

Subscriber Name: ______________________ Subscriber DOB: ______________

Subscriber Gender: M F Subscriber SSN: ______________ Subscriber I.D. #: ______________

Subscriber's relationship to patient (mother, father,grandmother, etc.): ______________________

I hereby authorize release of information necessary to file a claim(s) with my insurance company and assign benefits otherwise payable to me to Family Medical Centers.

I understand I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature shall be as valid as the original.

Patient Signature: Date:

Witness Signature: Date:

Emergency Contact:

Phone #: Cell #: Relationship: