

PARTNERS IN FAMILY CARE, P.C.

Please Print

PATIENT: This section refers to the PATIENT ONLY

Date: _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Sex: _____ Birth Date: _____

Spouse's Name: _____

Race: White _____ Black/African American _____ Amer. Indian/Alaskan Native _____

Asian _____ Native Hawaiian/Pacific Islander _____ Other _____

Are you of Spanish/Hispanic origin? Y _____ N _____

How may we reach you for:

Appointment Info:

Home phone: Y N
Cell Phone: Y N
Office: Y N
Mail Y N
Patient Portal Y N

Medical Info:

Y N
Y N
Y N
Y N
Y N

With another person? Y N Persons name: _____

Pharmacy – Primary _____ Mail Order _____

Previous Primary Care Physician: _____

Primary Insurance : _____

Insured Name: _____

Insured's ID Number: (on card) _____

Group Number: _____

Effective Date: _____

Subscriber/Guarantor: _____

Relationship to Patient: ___ Self ___ Spouse ___ Parent ___ Other

IN CASE OF EMERGENCY: (MUST BE COMPLETED)

Name, Address & Phone Number of Nearest Relative or Friend **NOT** living with you:

Name: _____

Address: _____

Phone Number: (_____) _____

Relationship to patient: _____

COMPLETE ONLY IF PATIENT IS A MINOR

Father's Name: _____

Social Security Number: _____

Work Phone: _____

Mother's Name: _____

Social Security Number: _____

Work Phone: _____

Child lives with: ___ Both Parents ___ Mother ___ Father

___ Other: _____

Who is financially responsible for child?: _____

Secondary Insurance :

Insured (Name on ID Card) _____

Insured Date of Birth: _____

Relationship to Patient: ___ Self ___ Spouse ___ Parent ___ Other

Insured's ID Number: _____

Group Number: _____

Effective Date: _____

PLEASE COMPLETE OTHER SIDE

Partners in Family Care, P.C.

MEDICARE PATIENTS ONLY:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR MEDIGAP BENEFITS BE MADE ON MY BEHALF TO: PARTNERS IN FAMILY CARE, P.C. I AUTHORIZE ANY NECESSARY MEDICAL INFORMATION ABOUT ME BE RELEASED TO THE HEALTH CARE FINANCING ADMINISTRATION AND IT'S AGENTS, OR MEDIGAP INSURANCE TO PROCESS AND PAY A CLAIM.

SIGNATURE OF PATIENT: _____ DATE: _____

COMMERCIAL /HMO INSURANCE PATIENTS ONLY:

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM, INCLUDING MENTAL HEALTH, DRUG, ALCOHOL OR HIV INFORMATION. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PARTNERS IN FAMILY CARE, P.C. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE FOR NON-ASSIGNED CLAIMS, OR ANY CO-INSURANCE OR DEDUCTIBLE FOR ASSIGNED CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ANY UNPAID CLAIM RESULTING FROM NOT FOLLOWING PROPER PROCEDURES OF INSURANCE PLAN.

SIGNATURE OF PATIENT: _____ DATE: _____

SELF-PAY PATIENTS ONLY

ANY PATIENT WHO IS SELF-PAY, PAYMENT IN FULL IS REQUIRED AT TIME OF VISIT.

SIGNATURE OF PATIENT: _____ DATE: _____

AUTHORIZATION TO FAX RECORDS:

I AUTHORIZE FAX TANSMISSION OF MY MEDICAL RECORDS TO OTHER PHYSICIAN OFFICES OR HOSPITAL AS THE NEED ARISES.

SIGNATURE OF PATIENT: _____ DATE: _____