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: (_____) _____

Birth Date: _____ Sex:_____

Social Security Number:_____

Spouse's Name: _____

Race (Check all that apply):

White ____ Black/African American ____

Amer. Indian/Alaskan Native ____ Asian ____

Native Hawaiian/Pacific Islander ____

Other ____

Are you of Spanish/Hispanic origin? Y_____ N_____

What is your Primary Language?_____

How may we reach you for:

Appointment Info:		**Medical Info:**	
Home phone:	Y N		Y N
Cell Phone/Text:	Y N		Y N
Office:	Y N		Y N
Mail	Y N		Y N
Patient Portal	Y N		Y N

With another person? Y N
Persons name: _____

Pharmacy – Primary_____

Mail Order_____

Previous Primary Care Physician:_____

PRIMARY INSURANCE:

_____

ID #:_____

SECONDARY INSURANCE:

_____

ID#:_____

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: _____

Work Phone: _____

Mother's Name: _____

Work Phone: _____

Child lives with: ____ Both Parents ____ Mother ____ Father

_____ Other: _____

Who is financially responsible for child?:_____

_____

PLEASE COMPLETE OTHER SIDE

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: _____

HIPAA NOTICE OF PRIVACY PRACTICES:

I HAVE RECEIVED THE NOTICE OF HIPAA ANDPRIVACY PRACTICES

SIGNATURE OF PATIENT:_____ DATE:_____