# 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:_____

**EMAIL ADDRESS:** _____

**PRIMARY INSURANCE:**

_____

ID #:_____

**SECONDARY INSURANCE:**

_____

ID#:_____

**IN CASE OF EMERGENCY: (MUST BE COMPLETED)**

Name, Address & Phone Number of Nearest Relative or Friend
That doesn't have the same phone number as 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**

# 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: _____

**HIPAA NOTICE OF PRIVACY PRACTICES:**

I HAVE RECEIVED THE NOTICE OF HIPAA ANDPRIVACY PRACTICES

SIGNATURE OF PATIENT:_____ DATE:_____