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| TODAY’S DATE: |
|  |
| PATIENT’S LAST NAME: FIRST: MIDDLE: |
| SOCIAL SECURITY NO.: BIRTH DATE:  - - | SEX: M F m |
| HOME ADDRESS: | CITY: | STATE: | ZIP CODE: |
| HOME PHONE NO.:( ) | WORK PHONE NO.:( ) | CELL PHONE NO.:( ) |
| EMAIL: | EMPLOYER: |
| EMERGENCY CONTACT: | EMERGENCY CONTACT RELATIONSHIP: |
| EMERGENCY CONTACT PHONE NO.:( ) |
| RACE: American Indian or Alaskan Native Asian Black or African Decline to Native Hawaiian or Pacific Islander White American Specify  |
| PRIMARY LANGUAGE SPOKEN:  | Primary Care Physician |
| ETHNICITY: Hispanic or Latino Not Hispanic or Latino Decline to Specify E |
| MARITAL Single Widow Married Divorced Separated Domestic  sIN STATUS: Partner   |
| **INSURANCE INFORMATION – Please Present Cards to Receptionist** |
| PATIENT COVERED BY INSURANCE: Yes No  |  Cash Patient |
| NAME OF PRIMARY INSURANCE: |
| POLICY HOLDER’S NAME: | POLICY HOLDER’S SOCIAL SECURITY NO.: | POLICY HOLDER’S BIRTH DATE: */ /*  |
| PATIENT’S RELATIONSHIP TO SUBSCRIBER: Self Spouse Child Other  |
| **SECONDARY INSURANCE INFORMATION** |
| NAME OF SECONDARY INSURANCE: |
| POLICY HOLDER’S NAME: | POLICY HOLDER’S SOCIAL SECURITY NO.: | POLICY HOLDER’S BIRTH DATE: */ /*  |
| PATIENT’S RELATIONSHIP TO SUBSCRIBER: Self Spouse Child Other  |

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| ***MEDICARE POLICY HOLDERS*** |
| 1). Do you or your spouse work for a company that provides you with health insurance? Yes No |
|  If retired, please indicate the date in which you retired \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| 2). Is the illness or injury the result of an automobile accident or other injury? Yes No |
| 3). Is the illness or injury the result of an accident or illness that occurred at work? Yes No |
| 4). Has treatment for this accident/illness been authorized by the Veteran’s Administration? Yes No |
| 5). Are you entitled to benefits under the Federal Black Lung Program? Yes No |

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| ***MINOR INFORMATION******FINANCIALLY RESPONSIBLE PARTY – Please Provide Insurance Cards to the Receptionist*** |
| FULL NAME: | SOCIAL SECURITY NO.: | BIRTH DATE:  */ /* |
| HOME ADDRESS (IF DIFFERENT FROM ABOVE): | CITY: | STATE: | ZIP CODE: |
| HOME PHONE NO.:( ) | CELL PHONE NO.:( ) | RELATIONSHIP TO PATIENT: |
| EMPLOYER: | EMPLOYER PHONE NO.: EXT.: |
| EMPLOYER ADDRESS:  | CITY: | STATE: | ZIP CODE: |

I hereby verify that this information is accurate.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_