

(TO BE COMPLETED BY FACILITY)

MEDICAL RECORD NUMBER: _____

PATIENT INFORMATION

PATIENT INFORMATION

Today's Date: _____ / _____ / _____
MONTH DAY YEAR

Name: _____
LAST NAME FIRST NAME MIDDLE NAME

Other / Maiden / AKA Name: _____
(OTHER NAME USED BY PATIENT) LAST NAME FIRST NAME MIDDLE NAME

Address: _____

City: _____ State: _____ Zip: _____ Home Telephone: (_____) _____
AREA CODE

Sex: M F Date of Birth: _____ / _____ / _____ Social Security Number: _____ - _____ - _____
MONTH DAY YEAR

Marital Status Single (S) Married (M) Widowed (W) Separated (SE) Divorced (D)

Primary Care Physician (PCP): _____ Referring Physician: _____
(IF DIFFERENT FROM PCP)

Employer: _____ Work Telephone: (_____) _____
AREA CODE

Address: _____ City: _____ State: _____ Zip: _____

Person to contact in an Emergency: _____ Emergency Telephone: (_____) _____
(NOT AT PATIENT'S ADDRESS) LAST NAME FIRST NAME AREA CODE

GUARANTOR INFORMATION

GUARANTOR INFORMATION — PERSON TO RECEIVE THE PATIENT'S BILL (COMPLETE INFORMATION ONLY IF DIFFERENT FROM PATIENT)

Name: _____
LAST NAME FIRST NAME MIDDLE NAME

Relationship of Patient to the Guarantor: Dependent Child (DEP) Spouse (SPO) Student (STU) Other (OTH) _____

Other / Maiden / AKA Name: _____
(OTHER NAME USED BY PATIENT) LAST NAME FIRST NAME MIDDLE NAME

Address: _____

City: _____ State: _____ Zip: _____ Home Telephone: (_____) _____
AREA CODE

Sex: M F Date of Birth: _____ / _____ / _____ Social Security Number: _____ - _____ - _____
MONTH DAY YEAR

Marital Status Single (S) Married (M) Widowed (W) Separated (SE) Divorced (D)

Employer: _____ Work Telephone: (_____) _____
AREA CODE

Address: _____ City: _____ State: _____ Zip: _____

HEALTH CARE COVERAGE

PRIMARY HEALTH CARE COVERAGE (INSURANCE) NAME: _____
(NAME OF INSURANCE)

Ins. Mailing Address: _____ City: _____ State: _____ Zip: _____

Ins. Telephone: (_____) _____ Effective Date of Coverage: _____ / _____ / _____ OFFICE VISIT COPAY: \$ _____
AREA CODE MONTH DAY YEAR

Policy or ID (Cert.) No.: _____ Group No.: _____ Plan Name or No.: _____

Relationship of Patient to Subscriber (Policy Holder): Self (SEL) Dependent Child (DEP) Spouse (SPO) Student (STU)
 Other (OTH): _____

Complete Subscriber (Policy Holder) information below ONLY if different from Patient

Subscriber's Name: _____
LAST NAME FIRST NAME MIDDLE NAME

Subscriber's Address: _____

City: _____ State: _____ Zip: _____ Subscriber's Telephone: (_____) _____
AREA CODE

Sex: M F Date of Birth: _____ / _____ / _____ Social Security Number: _____ - _____ - _____
MONTH DAY YEAR

ADDITIONAL HEALTH CARE COVERAGE

SECONDARY HEALTH CARE COVERAGE (INSURANCE) NAME: _____ (NAME OF INSURANCE)

Ins. Mailing Address: _____ City: _____ State: _____ Zip: _____

Ins. Telephone: (_____) _____ Effective Date of Coverage: ____/____/____ OFFICE VISIT COPAY:\$ _____
AREA CODE MONTH DAY YEAR

Policy or ID (Cert.) No.: _____ Group No.: _____ Plan Name or No.: _____

Relationship of Patient to Subscriber (Policy Holder): Self (SEL) Dependent Child (DEP) Spouse (SPO) Student (STU)
 Other (OTH) : _____

Complete Subscriber (Policy Holder) information below ONLY if different from Patient

Subscriber's Name: _____
LAST NAME FIRST NAME MIDDLE NAME

Subscriber's Address: _____

City: _____ State: _____ Zip: _____ Subscriber's Telephone: (_____) _____
AREA CODE

Sex: M F Date of Birth: ____/____/____ Social Security Number: _____
MONTH DAY YEAR

ADDITIONAL HEALTH CARE COVERAGE (INSURANCE) NAME: _____ (NAME OF INSURANCE)

Ins. Mailing Address: _____ City: _____ State: _____ Zip: _____

Ins. Telephone: (_____) _____ Effective Date of Coverage: ____/____/____ OFFICE VISIT COPAY:\$ _____
AREA CODE MONTH DAY YEAR

Policy or ID (Cert.) No.: _____ Group No.: _____ Plan Name or No.: _____

Relationship of Patient to Subscriber (Policy Holder): Self (SEL) Dependent Child (DEP) Spouse (SPO) Student (STU)
 Other (OTH) : _____

Complete Subscriber (Policy Holder) information below ONLY if different from Patient

Subscriber's Name: _____
LAST NAME FIRST NAME MIDDLE NAME

Subscriber's Address: _____

City: _____ State: _____ Zip: _____ Subscriber's Telephone: (_____) _____
AREA CODE

Sex: M F Date of Birth: ____/____/____ Social Security Number: _____
MONTH DAY YEAR

DEPENDENT INFORMATION Please list any additional family members who live at the same address and have the same insurance as the patient, and will also be seeing a health care provider in this office.

LAST NAME	NAME		SEX	DATE OF BIRTH			SOCIAL SECURITY #	NAME OF INSURANCE CO.
	FIRST NAME	MIDDLE NAME		MONTH	DAY	YEAR		
			<input type="checkbox"/> M <input type="checkbox"/> F	/	/			
			<input type="checkbox"/> M <input type="checkbox"/> F	/	/			
			<input type="checkbox"/> M <input type="checkbox"/> F	/	/			
			<input type="checkbox"/> M <input type="checkbox"/> F	/	/			
			<input type="checkbox"/> M <input type="checkbox"/> F	/	/			
			<input type="checkbox"/> M <input type="checkbox"/> F	/	/			
			<input type="checkbox"/> M <input type="checkbox"/> F	/	/			
			<input type="checkbox"/> M <input type="checkbox"/> F	/	/			
			<input type="checkbox"/> M <input type="checkbox"/> F	/	/			
			<input type="checkbox"/> M <input type="checkbox"/> F	/	/			
			<input type="checkbox"/> M <input type="checkbox"/> F	/	/			

DEPENDENT INFORMATION