|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_