The Family Health Center, P.C.

Account # _____

Patient Name: _____ **Social Security Number:** _____

Date of Birth: _____/_____/_____ **Sex:** ☐ Male, ☐ Female **Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widow

Mailing _____

Drivers License #:_____ State: _____ Expiration date:_____

Home Phone: (_____)_____ Work Phone: (_____)_____ Leave message? ☐ Yes, ☐ No

Message Phone: (_____)_____ Cell Phone: (_____)_____

E-mail Address: Leave message? ☐ Yes, ☐ No

I *authorize this office to send any/all information/communications regarding my treatment to this E-mail address. I accept and agree to this: Signature:*_____

Responsible party *information if patient is under age 18*

Name: _____ DOB:_____

Mailing _____ Physical _____

Address _____ Address _____

Responsible Party/SSN# Drivers License Number:

Employer: _____ Occupation: _____

Address: _____ Phone: (_____)_____

If patient is a child *(under age 18)* who may authorize treatment for them other than responsible party above?

Name: Relationship: Phone:

Emergency Contact*:* Nearest Friend or Relative Not Residing With You.

Name: Relationship: Phone:

Insurance Information

Do You Have Medical Insurance? ☐ Yes, (*If yes, we need to copy your card*),☐ no

If No, you understand payment is expected at time of service unless other arrangements have been made.

Insurance: _____ Secondary Insurance: _____

Address: _____ Address: _____

_____ _____

Policy Number: _____ Policy Number: _____

Group Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber Name: _____

Relationship: _____ Relationship:_____

Subscriber DOB: _____ Subscriber DOB: _____

Workman's Compensation? ☐ Yes, ☐ No, Company Name:_____

Auto Accident? ☐ Yes, ☐ No, Address: _____

Date of Accident:

Spouse Name: _____ SSN: _____

Address: _____ DOB: _____

Please List Other Immediate Family Members *(May use back of sheet if necessary)*

Name: _____DOB _____ ☐M, ☐ F Name: _____DOB _____ ☐M, ☐ F

Name: _____DOB _____ ☐M, ☐ F Name: _____DOB _____ ☐M, ☐ F

How did you hear about our office? May we thank them for their referral? ☐ Yes, ☐ No

☐ Ad, ☐ Phone Book, ☐ Friend or Relative (specify) _____ ☐ Other_____

I authorize this office to release to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.
I have been given/offered a copy of The Family Health Center, P.C.'s Notice of Privacy Practices.

Patient, Parent or Guardian Signature: _____ Date: _____