

Family Medical Centers
PATIENT INFORMATION

PLEASE PRINT CLEARLY

Account # _____

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: _____ Marital Status: _____

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

Home Phone #: _____ Cell#: _____ Social Security #: _____

Email Address: _____

Driver License Number: _____ State of License: _____

Employer's Name & Address: _____

Employer's Phone #: _____ Referring Physician: _____

If Patient is a Minor Please Complete This Section:

Father's Name: _____ Social Security Number: _____ Date of Birth: _____

Father's Employer: _____ Employer's Phone #: _____

Father's Employer's Address: _____

Mother's Name: _____ Social Security Number: _____ Date of Birth: _____

Mother's Employer: _____ Employer's Phone #: _____

Mother's Employer's Address: _____

If Patient is Married Please Complete This Section:

Spouse's Name: _____ Social Security Number: _____ Date of Birth: _____

Spouse's Employer: _____ Employer's Phone #: _____

Spouse's Employer's Address: _____

Does the patient have health insurance? _____ Yes _____ No

If your response was yes, please list the insurance company's names. Please have your insurance cards available to copy.

Primary Insurance Carrier: _____

Secondary Insurance Carrier(s): _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber Gender: M F Subscriber SSN: _____ Subscriber I.D. #: _____

Subscriber's relationship to patient (mother, father, grandmother, etc.): _____

I hereby authorize release of information necessary to file a claim(s) with my insurance company and assign benefits otherwise payable to me to Family Medical Centers.

I understand I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature shall be as valid as the original.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Emergency Contact: _____

Phone #: _____ Cell #: _____ Relationship: _____