PRACTICE MANAGEMENT CLINIC

Patient: ____ SSN: ____________________
(Last Name) (First Name) (MI)

Sex: Male Female Date of Birth: ________________ Marital Status: ________________

Race: White Black/African Am. Asian Am. Indian / Alaska Native Native Hawaiian
Other Pacific Islander

Ethnicity: Hispanic / Latino Non-Hispanic / Latino

Primary Language Spoken in Home: ____

Primary Pharmacy Name and Location: ____

Is this patient considered to be homeless? Yes No

Is the patient a Veteran? Yes No

Mailing Address: ____
(Street) (City) (State) (Zip)

Primary Phone: ____________ Home Cell Alternate Phone: ____________ Home Cell

Employer Name: ______________________________ Work Phone: ______________

Employer Address: ____
(Street) (City) (State) (Zip)

Name of Parent / Guardian if a Minor **OR** Spouse: ____

Relationship to Patient: Parent Legal Guardian Spouse

Date of Birth: ________________ SSN: ____________________

Mailing Address: ____
(Street) (City) (State) (Zip)

Primary Phone: ____________ Home Cell Alternate Phone: ____________ Home Cell

Employer: ______________________________ Work Phone: ______________

Primary Insurance Information: Health Insurance Self Pay

Give the receptionist your insurance cards for verification and scanning.

Primary Insurance Name: ____

Policy Holder's Name: ______________________________ **Date of Birth:** ____________

Policy / Member ID Number: ____________________ **Group #:** ____________________

Signature on File:

I authorize use of this form on **ALL** of my insurance submissions including Medicare and Medigap.
I authorize release of information to all my insurance companies.
I understand that **I am responsible for my bill**.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
I authorize payment to my doctor.
I authorize my photo to be taken as part of my medical record.
I permit a copy of this authorization to be used in place of the original.
My signature gives my consent for treatment and I understand that treatment does not guarantee a cure.

Responsible Party's name (Print): ____

Responsible Party's Signature: ______________________________ Date: ______________

Updated 12/07/2018