FAMILY CENTERED HEALTHCARE, PA

New Patient Information Form

Please fill in the following information as completely as possible.

Guarantor (Responsible Party) Information:

Name ______________________ Today's Date ______________

Address ______________________

Zip ______________ City ______________ State ______________

Telephone (   ) ______________ Marital Status ______________

Social Security # ______ ______ ______ Employer ______________

Date of Birth ___/___/___ Telephone (   ) ______________ Ext. ______ Advanced Directive: Yes ____ No ____

Patient Information:

Relation to Guarantor: Self____ Spouse____ Child____ Other_______

Last Name ______________ First Name ______________ MI ______

Maiden Name ______________ Social Security # ______ ______ ______

Address ______________________

Zip ______ City ______________ State ______ Email ______________

Telephone (   ) ______________ Referring Physician ______________

Date of Birth ___/___/___ Age ______ Employer ______________

Marital Status ______ Sex ______ Work Ph (   ) ______ Ext. ______ Cell Ph (   ) ______

Emergency Contact ______________ Relation ______________ Telephone (   ) ______________

Student: Yes ____ No ____ Full-time ____ Part-time ____ Name of School ______________

Is today's visit the result of auto accident? Yes ____ No ____ Work Injury? ____ Date ______________

Other Coverage ______________________

Spouse Name ______________ Employer ______________ Telephone (   ) ______________

Insured (Policyholder) Information---Primary Carrier:

Please present your insurance card(s) to front counter.

Ins Co Name ______________________ Policy # ______________

Address 1 ______________________ Group # ______________

Address 2/City St Zip ______________________

Patient Relation to Insured: Self ____ Spouse ____ Child ____ Other ____

Policy Holder Name/Address 1 ______________________

Address 2/City St Zip ______________________

Telephone (   ) ______________ Date of Birth ___/___/___ Sex ______

Employer ______________________

Insured (Policyholder) Information---Secondary Carrier:

Ins Co Name ______________________ Policy # ______________

Address 1 ______________________ Group # ______________

Address 2/City St Zip ______________________

Patient Relation to Insured: Self ____ Spouse ____ Child ____ Other ____

Policy Holder Name/Address 1 ______________________

Address 2/City St Zip ______________________

Telephone (   ) ______________ Date of Birth ___/___/___ Sex ______

Employer ______________________

I authorize the release of all medical records to referring physicians and to my insurance company. I further authorize insurance payments to be made directly to FAMILY CENTERED HEALTHCARE, PA. I understand payment is due at time of service.

Signature of Responsible Party ______________________________ Date ______________