PATIENT Marital Status ( )M ( )D ( )W ( )S

Name:_____

Sex ( )M ( )F Date of Birth____/____/____

Physical Address (NO PO BOX):

_____

_____

(City) (State) (Zip)

Mailing Addresss:_____

_____

(City) (State) (Zip)

****Home Phone:( )_____ ***Cell Phone:( )_____

RESPONSIBLE PARTY: ( )Self ( )Spouse ( ) Parent

Name:_____

Sex ( )M ( )F Date of Birth:____/____/____

Social Security #_____

Address:_____

_____

(City) (State) (Zip)

Home Phone:( )_____

Relationship to Patient_____

Employer Name:_____

Address:_____

_____

(City) (State) (Zip)

Work Phone:( )_____

Employer Name:_____

Address:_____

_____

(City) (State) (Zip)

Work Phone:( )_____

PRIMARY INSURANCE

Ins. Company:_____

Claims Mailing Address:_____

_____

(City) (State) (Zip)

Phone:( )_____

Policy Holder Name:_____

Sex:( )M ( )F date of birth____/____/____

Policy # _____

Group#_____

Effective date:____/____/____ Co-Pay$:_____

SECONDARY INSURANCE

Ins. Company:_____

Claims Mailing Address:_____

_____

(City) (State) (Zip)

Phone:( )_____

Policy Holder Name:_____

Sex:( )M ( )F date of birth____/____/____

Policy # _____

Group#_____

Effective date:____/____/____ Co-Pay$:_____

Emergency Contact:_____Phone: ( )_____ Relationship_____

ASSIGNMENT & RELEASE: I HEREBY AUTHORIZE Price Family Medicine to treat the above named patient. I AUTHORIZE RELEASE OF MEDICAL INFORMATION necessary to process insurance claims concerning my ill-ness and treatment. Photocopies are valid as original. I AUTHORIZE PAYMENT of medical benefits for medical care rendered to myself of my dependents. I understand I am financially responsible for any amounts not covered by my health insurance.

SIGNATURE:_____ DATE:____ _____