Tri-City Family Care

Jeramiah Walker APRN-CNP | Board Certified Family Nurse Practitioner

PATIENT INFORMATION

Date	Referring Physician	Referring Physician Phone	
Last	First	Middle	Sex ❑ M ❑ F
Address	City	State	Zip
Home Telephone ( )	Age	Birthdate / /	Marital Status S M W D DEP	SS# — —
Employer/School	Address	City	State	Zip
Work Phone & Ext. ( )	Cell Phone	Pager	E-Mail
Patient's Nearest Relative (Other than Spouse)	Relation	Home Phone ( )	Work Phone & Ext. ( )

RESPONSIBLE PARTY INFORMATION

Spouse/Parent	Relation to Patient	Home Telephone ( )	
Address	City	State	Zip
Employer	SS# — —	Birthdate / /	Age	Work Phone & Ext. ( )

INSURANCE INFORMATION (Provide cards to copy)

Primary Insurance	Insurance Type ❑ Group ❑ Individual ❑ Cobra		
Address	City	State	Zip
Insured's Name on Card	I.D. #	Group #	
Insured's Birthdate / /	Patient Relation to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other	Insured's Sex ❑ M ❑ F	Insured's SS# — —
Insured's Employer	Telephone & Ext. ( )		

Secondary Insurance	Insurance Type ❑ Group ❑ Individual ❑ Cobra		
Address	City	State	Zip
Insured's Name on Card	I.D. #	Group #	
Insured's Birthdate / /	Patient Relation to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other	Insured's Sex ❑ M ❑ F	Insured's SS# — —
Insured's Employer	Telephone & Ext. ( )		

OTHER INFORMATION

I authorize the release of medical information required to process all claims on my behalf. I also authorize payment of insurance benefits from those claims be made payable to: Tri-City Family Care. I understand I am financially responsible for any charge not covered by my insurance.

PATIENT OR AUTHORIZED PERSON ______________________ DATE ____________