Patient Information

Name: _____ DOB: _____

Driver's License: _____ SSN: _____

Address: _____ Zip code: _____

Primary Phone: _____ Cell Phone: _____ Okay to text? ☐

Email: _____

☐ Please check box to consent to Patient Portal in order to receive results

Emergency Contact Information

Contact: _____ Phone: _____ Relationship: _____

Contact: _____ Phone: _____ Relationship: _____

Insurance

Primary Insurance: _____ Policy #: _____

Insured Party: _____ Relationship to Patient: _____

Insured Party DOB: _____ Insured Party SSN: _____

Secondary Insurance (if any): _____ Policy #:_____

Insured Party: _____ Relationship to Patient: _____

I verify that all the above information is factual and true to the best of my knowledge. I authorize Essential Family Medicine to draw labs in office and/or refer for any radiology studies, surgeries that may be necessary in order to provide proper patient care. I understand that payment, proof of insurance and/or copay is due at the time of service.

As a courtesy to our staff and other patients, we require a 24 hour notice for all appointment cancellations. Notification must be made to our office directly. Failure to do so will result in a $25 charge added to your account with Brandee Yarbrough, APRN. This fee must be paid prior to any future appointments.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

_____ _____

Patient Signature Date