

The Family Physicians Group, P.C.

PATIENT INFORMATION

Please Complete All Blanks

PATIENT										
NAME, LAST			FIRST				M.I.	AGE	DATE OF BIRTH	SEX
ADDRESS			CITY		STATE	ZIP		PHONE		
SOCIAL SECURITY NO.	MARITAL STATUS:		DIVORCED		Have you or any member of your family been treated by these physicians before?		YES	UNDER WHAT NAME		DATE
		WIDOWED		MARRIED		SINGLE		NO		
OCCUPATION			NAME OF EMPLOYER OR SCHOOL							
EMPLOYER'S ADDRESS			CITY		STATE	ZIP		PHONE		
WHO REFERRED YOU TO OUR OFFICE?		Another Patient	Yellow Pages	Med Search	NAME			ADDRESS		
		Another Physician	"Doctors"	Newspaper Ad						
WHY DID YOU CHOOSE OUR OFFICE?		LOCATION		HOURS	REPUTATION	INSURANCE				
IN CASE OF EMERGENCY NOTIFY:		NAME			STREET ADDRESS, CITY, STATE & ZIP CODE				PHONE	

PRIMARY INSURANCE HOLDER INFORMATION / FINANCIALLY RESPONSIBLE PARTY									
NAME			ADDRESS					PHONE	
SOCIAL SECURITY NO.	OCCUPATION			NAME OF EMPLOYER			DATE OF BIRTH		
EMPLOYER'S ADDRESS			CITY		STATE	ZIP		PHONE	

INSURANCE										
PRIMARY INSURANCE		MAIL FORM TO: STREET ADDRESS			CITY	STATE	ZIP	PHONE		
EMPLOYER				INSURED'S NAME				DATE OF BIRTH		
POLICY OR I.D. #	GROUP OR OTHER NO.		RELATION TO PATIENT							
				SELF		SPOUSE		CHILD		OTHER:
SECONDARY INSURANCE		MAIL FORM TO: STREET ADDRESS			CITY	STATE	ZIP	PHONE		
EMPLOYER				INSURED'S NAME				DATE OF BIRTH		
POLICY OR I.D. #	GROUP OR OTHER NO.		RELATION TO PATIENT							
				SELF		SPOUSE		CHILD		OTHER:

PLEASE READ AND SIGN

I hereby authorize and consent for testing and/or treatment by the Family Physicians Group (TFPG) and to furnish information to insurance carriers regarding this treatment. I hereby assign to TFPG all insurance benefits payable for services but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by benefits. I agree to be responsible for any reasonable collection costs associated with collection of this account including attorney fees, litigation costs, and collection agency fees.

PLEASE NOTE: There will be a \$39.00 charge for returned checks.

Signature _____

Date _____