Howard Rheumatology

Patient Information

LAST NAME _____ FIRST NAME _____ MIDDLE _____

MAILING ADDRESS _____ APT ____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____DOB ____ AGE ____ SS# _____ MARITAL STATUS _____

WORK PHONE _____ CELL PHONE _____ EMAIL _____

PREFERRED COMMUNICATION: TEXT PHONE PORTAL LETTTER (CIRLCE ONE PLEASE)

ETHNICITY: HISPANIC _____ NON-HISPANIC _____ RACE _____ I DECLINE TO LIST MY RACE _____

PRIMARY PHYSICIAN _____ REFERING PHYCISIAN _____

PHARMACY LOCAL _____ MAIL ORDER PHARMACY_____

PRIMARY LANGUAGE SPOKEN: ENGLISH_____ OTHER _____

EMPLOYER _____ OCCUPATION _____ STUDENT _____

EMERGENCY CONTACT _____ CONTACT PHONE _____

WHO IS RESPONSIBLE FOR THIS VISIT YOURSELF SPOUSE GUARANTOR PARENT **DISREGARD NEXT SECTION IF YOU ARE THE RESPONSIBLE PARTY**

LAST NAME _____ FIRST NAME _____ MIDDLE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____ DOB _____ SS# _____

EMPLOYER _____ OCCUPATION _____ PHONE _____

INSURANCE INFORMATION

NAME OF POLICY HOLDER _____ DOB _____ SSN# _____

PRIMARY INSURANCE _____ **HMO PPO ICA SELF PAY** EMPLOYER _____

ID# _____ GROUP# _____ INSURANCE COMPANY PHONE _____

INSURANCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY INSURANCE HMO PPO ICA SELF PAY POLICY HOLDER

ID# _____ GROUP# _____ INSURANCE COMPANY PHONE _____

INSURANCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

IF THIS IS **INDUSTRIAL** PLEASE PROVIDE THE FOLLOWING: DATE OF INJURY _____ CARRIER _____

CLAIM# _____ CLAIMS ADJUSTOR _____ PHONE _____

Signature of patient or patient/guardian if minor _____Date_____