Hometown Direct Primary Care

332 N. Bright Leaf Blvd, Suite C
P.O. Box 2559
Smithfield, NC 27577
Phone (919) 901-7344 Fax (319) 250-7453

Patient Information

Patient Name: _____ SSN: _____

Address: _____ DOB: _____

City: _____ State: _____ Zip: _____ Sex: M F

Home phone: _____ Cell: _____ Work: _____

Email: _____ Marital status: _____

Employer: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Spouse/Parent/Guardian or Responsible party (if different from patient)

Name: _____ SSN: _____

Address: _____ DOB: _____

City/State: _____ Zip: _____ Relationship: _____

Home phone: _____ Cell: _____ Work: _____

Employer: _____ Email: _____

Emergency Contact

Name: _____ Phone: _____

Alternate phone: _____ Relationship: _____

Insurance Information

Primary Insurance: _____ Policy #: _____ Grp #: _____

Main policy holder: _____ Relationship to patient: _____

Secondary Insurance: _____ Policy #: _____ Grp #: _____

Main policy holder: _____ Relationship to patient: _____

I verify that the information above is factual and true to the best of my knowledge. I authorize the doctor to employ X-rays, laboratory studies, anesthetics, medications, minor procedures, and other aids he/she deems necessary in order to provide proper patient care.

Signature: _____ Date: _____