Family Health Center of Mission

****Please fill in all areas clearly — Receptionist needs to make a copy of your driver's license and all insurance cards****

Patient Information

Patient's Legal Name: _____ ____ _____ _____/_____/_____
First Name Initial Last Name Date of Birth: M/D/Y

Address: _____
STREET CITY STATE ZIP

Telephone: (_____) _____ HOME (_____) _____ MOBILE (_____) _____ WORK

Social Security #: _____ - _____ - _____ Driver's License #:_____

Email Address: _____ Employment Status:_____
*
Employed, Unemployed, retired, Military

Marital Status (circle one): Single Married Widowed Sex (circle one): Male Female

Race (circle one): Hispanic White Black Am Indian Asian Other: _____

Spouse's Name (if married): _____ Name of Legal Parent/Guardian if minor:_____

Alternate Mailing Address: _____
STREET CITY STATE ZIP PHONE

Alternate Contact Person (Another friend or relative who does not live with you)

Name: _____ Address: _____
STREET CITY STATE ZIP

Telephone: (_____) _____ Relationship to Patient: _____

Person Responsible for Payment (Guarantor)

Name: _____ Relation to Patient: _____Guarantor's DOB _____

Social Security #: _____ - _____ - _____ Driver's License #: _____ State: _____

Employer: _____ Address _____

Telephone: (_____) _____ HOME (_____) _____ WORK (_____) _____ MOBILE

Payment is expected at time of service unless prior arrangements have been made
I will pay for today's medical expenses as follows (circle one or more): Cash Check Visa MC AmExp Discover

Insurance Information (please check all that apply)

____ I do not have any insurance coverage at this time

____ ***Primary Policy*** MEDICARE #: _____ MEDICAID #: _____

If you have private health insurance, please complete the following:

Name of Insurance: _____ Name of Policy Holder: _____DOB_____

Policy #: _____ Group #: _____ Plan Name: _____

____ ***Secondary Policy*** MEDICARE #: _____ MEDICAID #: _____

If you have private health insurance, please complete the following:

Name of Insurance: _____ Name of Policy Holder: _____DOB_____

Policy #: _____ Group #: _____ Plan Name: _____

I hereby authorize the Attending Physician to furnish my referring physician, insurance company(s), attorney, or legal representative all information, which said parties, may request concerning my present condition or illness. I consent to the use and disclosure of my protected health information for the purposes of treatment, payment and health care operations. I understand that I am fully responsible for any charges for services that have been provided to me and accept sole responsibility for payment of these services in the event that they are denied or excluded by my insurance company(s).I also understand that the account will be referred to an outside collection agency if timely payment is not made. I hereby assign to the Attending physician all monies entitled for services rendered, and will promptly pay the Attending Physician any monies my insurance company may pay me that are due to the Attending Physician. A Photostat copy of this form shall be considered as effective and valid as the original.

Signature of Patient (or Legal Representative): _____ Date: _____

2/2016 updated

Office Use Only: ____ Employee ____ All Information Complete ____ Copy of Driver's License ____ Copy of ALL Insurance Cards ____ Patient Signature