**PATIENT INFORMATION**

**Partners in Family Medicine**

|  |  |
| --- | --- |
| **Name:** | **Home Phone#:** |
| **Date of Birth:** | **Work Phone#:** |
| **Sex:** | **Cell Phone#:** |
| **Address:** | **Marital Status:** |
|  | **Email Address:** |
| **City:** | **Emergency Contact:** |
| **State: Zip:** | **Emergency Phone#:** |

**RESPONSIBLE PARTY INFORMATION**

|  |  |
| --- | --- |
| **Name:** | **Home Phone#:** |
| **Date of Birth:** | **Work Phone#:** |
| **Address:** | **Cell Phone#:** |
|  | **Employer:** |
| **City:** | **Employer Address:** |
| **State: Zip:** | **Employer City:** |

**INSURANCE and CARD HOLDER INFORMATION**

|  |  |
| --- | --- |
| **Primary Insurance:** | **Secondary Insurance:** |
| **Contract #:** | **Contract#:** |
| **Group Number:**  **Group Name:** | **Group Number:**  **Group Name:** |
| **Copay:** | **Copay:** |
| **Subscriber Name:** | **Subscriber Name:** |
| **Subscriber DOB:** | **Subscriber DOB:** |

I acknowledge this information is accurate to the best of my knowledge.

Signed (patient or parent if minor) Date