**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