Partners in Family Medicine
6000 24 Mile Road
Shelby Township, MI 48316

PATIENT INFORMATION

Name:	Home Phone#:
Date of Birth:	Work Phone#:
Sex:	Cell Phone#:
Address:	Email Address:
City:	Emergency Contact:
State: Zip:	Emergency Phone#:

RESPONSIBLE PARTY INFORMATION (billing statement purposes)

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.

X _____ _____

Signature of Patient/Representative Date