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| PATIENT INFORMATION(Please print) |
| Patient’s Last name:  |  First: |  Middle: |
|  |
| Marital status (circle one):Single / Married  | Social security no: | Birth date: | Age: | Sex: |
|  / / |  | ❑ M | ❑ F |
| Street address: | Home phone: |
| ( ) |
| City: | State: | ZIP Code: | Cell phone:  |
|  |  |  | ( ) |
| Race:  | Ethnicity: | Language Preference:  |
| ❑ Vietnamese ❑ Hispanic ❑ White ❑ African-American ❑ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Nonhispanic ❑ Hispanic  | ❑ Vietnamese ❑ Spanish ❑ English❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Emergency Contact: | Relationship to patient: | Phone:( ) |
| Email:  |
| Preferred pharmacy phone: ( )  |  Pharmacy fax: ( ) |
|  |
| INSURANCE INFORMATION |
| Please indicate primary insurance | ❑ Aetna |  ❑ Amerigroup/Medicaid  | ❑ BCBS | ❑ Humana | ❑ Memorial Hermann |
|  | ❑ CHC |  ❑ United HealthCare |  ❑ Cigna | ❑ Selfpay ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: / / |
|  |  |
| Policy number:  | Group number:  |
| Patient’s relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |
| Assignment and release |
| **I, the undersigned certify that I (or my dependent) have insurance coverage with the above named insurance.** **I assign directly to PROVIDENCE FAMILY PRACTICE, P.A. all insurance benefits, if any, otherwise payable to me for services rendered. *I understand that I am financially responsible for all charges, whether or not paid by insurance.* All fees will be paid at the time of service unless other arrangements are made in advance. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.****\_\_\_\_\_\_\_ (Initial) I have reviewed the HIPAA privacy practice form and give my permission to Providence Family Practice to use or disclose my health information in accordance with the guidelines of HIPAA regulation.****\_\_\_\_\_\_\_\_(Initial) I have reviewed all clinic policies given to me. I understand and agree to abide by all clinic policies.** |
|  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Patient/Guardian Signature Relationship Date** |  |
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