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| PATIENT INFORMATION (Please print) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s Last name: | | | | | | First: | | | | | Middle: | | | | | | | | | | | | | | | | | | |
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| 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: | | | | | | | | | |
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| 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: ( ) | | | | | | | | | | | | | | | | | | | |
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| 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:  / / | | | | | | | |
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| Policy number: | | | | | | | | | | | | | | Group number: | | | | | | | | | | | | | | | |
| Patient’s relationship to subscriber: | | | ❑ Self | | | | | ❑ Spouse | | | | ❑ Child | | | | ❑Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |  | | | | |
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| 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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