PATIENT INFORMATION

Patient's last name/Tên họ: First/Tên: Middle/Tên lót:				
Marital status/Trạng hôn nhân: Single / Married	SSN/Số an sinh xã hội:	Birth date/Ngày sanh: / /	Age/tuổi:	Sex: ❑ M ❑ F
Street address/Địa chỉ nhà:				Home phone/Điện thoại nhà: ( )
City/Thành phố:	State/Tiểu bang:	Zip Code/Mã bưu chính:		Cell phone/Điện thoại hãng: ( )
Race/Chủng tộc: ❑Vietnamese ❑Hispanic ❑White ❑ African-American ❑Other:_____		Ethnicity/Dân tộc: ❑Nonhispanic ❑Hispanic	Language Preference/Ngôn ngữ : ❑Vietnamese ❑Spanish ❑English ❑ Other: _____	
Email address (**Required***):				
Pharmacy name/Tên nhà thuốc (**Required***):		Pharmacy phone/Diện thoại nhà thuốc (**Required***): ( )		
Emergency contact/Người liên lạc (**Required***):	Relationship to patient/Mối quan hệ với bệnh nhân:	Phone/Điện thoại: ( )		

INSURANCE INFORMATION (REQUIRED*)

Primary insurance/Tên bảo hiểm:	❑ Aetna	❑ Blue Cross Blue Shield	❑Cigna	❑ Humana	❑ Memorial Hermann
	❑ Community Health Choice	❑ United HealthCare	❑ Medicare	❑ Selfpay	❑ Other: _____

Subscriber name/Tên người đăng ký:	Subscriber SSN/Số an sinh xã hội.:	Birth date/Ngày sanh: / /
Policy number/Số ID:	Group number/Số nhóm:	
Patient relationship To subscriber/Mối quan hệ với bệnh nhân: ❑ Self ❑ Spouse ❑ Child ❑Other: _____		

ASSIGNMENT AND RELEASE (REQUIRED*)

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above named insurance or will be paying out of pocket. 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.

x_____ **(Please initial here*)** 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.

x_____ **(Please initial here*)** I have reviewed all clinic policies given to me. I understand and agree to abide by all clinic policies.

_____ _____

Patient/Guardian signature/Tên ký ***Date/Ngày hôm nay***