PATIENT INFORMATION

Name: _____

Address: _____

Apt#:_____ City: _____

State: _____ Zip: _____

Primary Phone: _____

Second Phone #: _____

Email address: _____

Date of Birth: _____ Sex: ( ) M ( ) F

Social Security #: _____

Marital Status: ( ) Married ( ) Partnered

( ) Single ( ) Divorced ( ) Widowed

PATIENT EMPLOYMENT / SCHOOL

( ) Employed ( ) Retired ( ) Self

( ) Unemployed ( ) Other

Employer/School: _____

Work Phone #: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone #: _____

Alternate Phone # _____

PHARMACY

Retail Pharmacy: _____

Pharmacy Phone #: _____

Address or Intersection: _____

Mail Order Pharmacy: _____

Mail Order Pharmacy Phone #: _____

RESPONSIBLE PARTY

( ) Same as Patient

Name: _____

Address: _____

Apt. #: _____ City: _____

State: _____ Zip: _____

Primary Phone #: _____

Date of Birth: _____

EMPLOYMENT

Employer: _____

Work Phone #: _____

POLICYHOLDER INFORMATION

Insurance Company: _____

Insured Name: _____

Relationship to Patient: _____

Insured Social Security #: _____

Insured Date of Birth: _____

Address: _____

(if different from above) _____

ID #: _____

Group #: _____

Employer: _____

Primary Phone #: _____

See Other Side

UPDATED: 8/7/2015

SECONDARY INSURANCE COMPANY

Insurance Company: _____

Insured Name: _____ ID #: _____

Relationship to Patient: _____ Group #: _____

Insured Social Security #: _____ Employer: _____

Insured Date of Birth: _____ Work Phone #: _____

Address: _____

(if different from above) _____

FAMILY MEMBERS IN THIS PRACTICE

Name: _____ Date of Birth: _____ Relationship: _____

Name: _____ Date of Birth: _____ Relationship: _____

Name: _____ Date of Birth: _____ Relationship: _____

Name: _____ Date of Birth: _____ Relationship: _____

FEDERALLY REQUIRED QUESTIONS

Primary Language:

- o English
- o Spanish

Other:_____

Race:

- o Hispanic
- o White
- o Black/African American
- o American Indian
- o Asian
- o Native Hawaiian
- o Other Pacific Islander
- o Other race: ___

Ethnicity:

- o Hispanic
- o Non-hispanic

Acknowledgment of Financial Agreement

I hereby acknowledge the above information is true and correct. I give authorization for payment for insurance benefits to be made directly to Highlands Family Medicine (HFM) for services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize HFM to release all information necessary to secure the payment of benefits.

Patient/Responsible Party Signature: _____ **Date:** _____

Receipt of Privacy Practices

I have reviewed the notice of privacy practice form for my records and have taken or been offered a copy. I understand the responsibilities of HFM in regards to my Personal Health Information.

Patient/Responsible Party Signature: _____ **Date:** _____