CENTER FOR FAMILY MEDICINE, P.A.

PATIENT DEMOGRAPHICS

Name_____ DOB _____ SSN_____

Address_____ City _____ State _____ Zip_____

Mailing Address_____ City_____ State_____ Zip_____

Phone Number _____ Alternate Phone Number _____

E-Mail address _____ Preferred Contact Method _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced Sex: ☐Female ☐Male

Race: ☐American Indian ☐Asian ☐Black or African American ☐Native Hawaiian ☐White ☐Other _____

Ethnicity: ☐Hispanic or Latino ☐Latin American ☐Mexican American ☐Not Hispanic or Latino ☐Other (please list)_____

Preferred Language_____

Employer_____ Occupation_____

Emergency Contact _____ Relationship to patient _____

Phone #_____ Alternate Phone # _____

Preferred Pharmacy _____ Phone Number_____

Primary Care Physician: ☐Cooper ☐Russell ☐Schulze ☐Hodge ☐Woods ☐Haney ☐Young ☐Marr ☐Mitchell

Responsible Party for Minors

Name _____ DL # _____ Issuing State_____

Address _____ City _____ State _____ Zip _____

Primary Contact Number _____ Relationship to Patient _____

Primary Insurance Information

Insurance Company _____ Address _____

Member ID # _____ Group # _____ Phone # _____

Policy Holders Name _____ DOB _____ SSN _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Secondary Insurance Information (if applicable)

Insurance Company _____ Address _____

Member ID # _____ Group # _____ Phone # _____

Policy Holders Name _____ DOB _____ SSN _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Assignment of Benefits and Financial Agreement

I hereby authorize payment of insurance benefits to be made to Center for Family Medicine, PA and any assisting physicians, 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 fees. I also authorize Center for Family Medicine, PA to release any and all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date _____ Signature _____