

PATIENT INFORMATION

FIRST NAME _____ INITIAL _____ LAST NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____

DATE OF BIRTH _____ SOCIAL SEC. # _____

() SINGLE () MARRIED () WIDOWED () DIVORCED () SEPARATED

EMPLOYERS NAME _____ OCCUPATION _____

BUSINESS ADDRESS _____

BUSINESS PHONE _____

IN CASE OF AN EMERGENCY, WHO SHOULD BE NOTIFIED?

NAME _____ HOME PHONE _____

RELATIONSHIP _____ WORK PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____

ID # OR POLICY # _____ GROUP # _____

SUBSCRIBER NAME _____ SUBSCRIBER DOB _____

SECONDARY OR SUPPLEMENTAL INSURANCE _____

ID # OR POLICY # _____ GROUP # _____

SUBSCRIBER NAME _____ SUBSCRIBER DOB _____

PLEASE READ AND SIGN THE FOLLOWING

I hereby authorize Plaza Family Care, PC to furnish information to insurance carriers concerning my illness & treatments, and I hereby assign to the medical group all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance.

SIGNED: _____ DATE: _____