

Family Healthcare Associates

PATIENT INFORMATION

2) _____
Patient Last Name First Name M.I.
12) _____
Street Address Apt.# City State Zip
3) Sex _____ 4) Birthdate _____ 5) SSN _____
14) () _____ - _____ 15) () _____ - _____ 16) () _____ - _____
Home Phone Work phone Cell Phone
104) Ethnicity: ___ Caucasian ___ African American ___ Hispanic ___ American Indian ___ Asian ___ Other
112) Employment Status: Full-time / Part-time / Not Employed / Self / Retired / Active Duty (circle one)
113) Student Status: Full-time / Part-time / Not a Student (circle one) 83 _____
Driver license number
82) Emergency Contact Name _____ Relationship to Patient _____ Phone _____

PRIMARY INSURANCE INFORMATION

20) Primary Insurance _____ 21) Policyholder _____
22) Policyholder's Sex _____ 23) Policyholder's DOB _____ 24) Policyholder's SSN _____
25) Patient's Relationship to Policyholder _____ 30) Policy Effective Date _____
29) Policyholder's Employer _____ 37) Member ID# _____
Employer's Address _____ Group Number _____
City _____ State _____ Zip _____ 31) Policyholder's ID# _____
33) Policy Type: Is this insurance coverage obtained thru an employer? Yes No (circle one)

SECONDARY INSURANCE INFORMATION

40) Secondary Insurance _____ 41) Policyholder _____
42) Policyholder's Sex _____ 43) Policyholder's DOB _____ 44) Policyholder's SSN _____
45) Patient's Relationship to Policyholder _____ 50) Policy Effective Date _____
49) Policyholder's Employer _____ 57) Member ID# _____
Employer's Address _____ Group Number _____
City _____ State _____ Zip _____ 51) Policyholder's ID# _____
53) Policy Type : Is this insurance coverage obtained thru an employer? Yes No (circle one)

Authorization for Payment and to Release Information

I hereby authorize payment to Family HealthCare Associates of any medical or surgical benefits. I authorize Family HealthCare Associates to release medical records, including HIV testing and/or drug/alcohol use and testing, as requested by representatives of insurance companies or other related organizations for payment of claims, for quality assurance/management or utilization management purposes. I acknowledge that any photographs taken by Family Healthcare Associates and/or its employees and contractors will become part of my medical record and may be disclosed in accordance with Family Healthcare Associates's Notice of Privacy Practices. Despite the risk that information transmitted electronically or through facsimile (fax) communication devices may be intercepted or inadvertently transmitted to people not authorized to receive the information, I hereby authorize the transmission of my medical record, or any part thereof, electronically and through facsimile (fax) communication devices. Additionally, I understand that some procedures/services performed by the physician(s) may not be covered by my insurance plan. If services are not covered, I understand and agree to be financially responsible for payment for such services.

8) Signature _____ 17) Date _____

Printed Name _____