Payment Method:

AllScripts ID: _____

_____

Scanned by: _____

Patient Information

Pt ID#: _____ Date: ____/____/____

First Name: _____ MI: _____ Last Name:_____

*SS#_____-_____-_____ DOB: _____/_____/_____ Gender: Male / Female

(*Last 4 SS# required; full SS# for work/auto related cause)

Address:_____ Apt/Lot#:_____

City: _____ State: _____ Zip Code: _____

Primary Phone: (_____)_____ Secondary Phone: (_____)_____

Email: _____ ☐I do not wish to provide an email for patient portal

Primary Care Physician: _____ Phone: (_____) _____

Preferred Language: _____

Race:

☐African Ameri ☐ Caucasian ☐Asian ☐American Indian/Alaskan Native

☐Native Hawaiian/Pacific Islander ☐ Other: _____ ☐Decline to Specify

Ethnicity:

☐Hispanic/Latino ☐ Non - Hispanic/Latino

☐Decline to Specify

How did you Hear About Us (Please Check One)

Building Sign Drive by Employer Established Patient

Family/Friend Internet/Web Walk-in

Parent/Guardian Information (Minor patients under the age of 18/power of attorney**must have documents)

First Name: _____ MI: _____ Last Name: _____

Is the address the same as the patient?☐ Yes ☐ No If "NO" please complete the address information below

Relationship to Patient: Parent Legal Guardian Other: _____

Address: _____ Apt/Lot#: _____ City: _____ State: _____ Zip: _____

Birth Date: ___/___/____ Social Security Number: _____/_____/_____ Gender: ☐ Male ☐ Female

Emergency Contact Information (Fill out address **ONLY** if different from patient)

Emergency Contact Name: _____

Address: _____ Apt/Lot#:____ Primary Phone: (_____)_____

City: _____ State: ____ Zip Code: _____ Secondary Phone: (_____)_____

Relationship to patient: _____

Primary Insurance Information

Name of Primary Insurance Carrier: _____

Insurance Number: _____ Group Number: _____

Subscriber Full Name: _____

Subscribers DOB: ___/___/____ Subscribers Gender: ☐ Male ☐ Female

Subscriber Relationship to Patient:

☐Self ☐Spouse ☐Parent ☐Legal Guardian ☐Other: _____

☐Urgent Care - Co-pay Amount: $_____

Secondary Insurance Information

Name of Secondary Insurance Carrier: _____

Insurance Number: _____ Group Number: _____

Subscriber Full Name: _____

Subscribers DOB: ___/___/____ Subscribers Gender: ☐ Male ☐ Female

Subscriber Relationship to Patient:

☐Self ☐Spouse ☐Parent ☐Legal Guardian ☐Other: _____

☐Urgent Care - Co-pay Amount: $_____

Acknowledgment/Reason for Visit

Reason for today's visit: _____

By signing below, I _____ Acknowledge that the information I have provided on this form is true and accurate and that I may be held financially responsible for any missing, incorrect, or invalid information associated with this patient and the services rendered at our facility.

Patient / Parent signature: _____ **Date:** _____

Office Use Only

Please check type of verification information obtained and scanned / copied:

☐Current driver's license / state issued photo ID

☐Current Insurance card(s)

☐ Offered patient portal access

FD initials: _____