PATIENT INFORMATION: DATE: _____

Name (Last, First, M.I.) _____

Address _____

City, State & Zip _____

Telephone Number (Home) _____ (Cell) _____ (Preferred) _____

Birthdate _____/_____/_____ Age _____ Social Security # _____

Person to contact in case of emergency. Name _____ Phone # _____

Email Address _____

Patient Status: Married _____ Single _____ Widowed _____ Other _____
Legally Separated _____ Divorced _____

Employment Status: Employed, Full-time _____ Employed, Part-time _____ Retired _____
Not Employed _____ Student, Full-time _____ Student, Part-time _____

Employers Name _____

Address & Telephone Number _____

Primary Care Physician: _____ Referred by: _____

Relationship to Guarantor: Self _____ Spouse _____ Child _____ Other _____

RESPONSIBLE PARTY FOR INSURANCE:

Name (Last, First, M.I.) _____

Address _____

City, State & Zip _____

Telephone Number (Home) _____ (Cell) _____ (Work) _____

Birthdate _____/_____/_____ Age _____ Social Security # _____

Insured Employer's Name _____

Address & Telephone Number _____

INSURANCE INFORMATION:

Primary Insurance Company _____

Insurance Address _____

Policyholder's Name _____

Policyholder's Birthdate _____/_____/_____ Policyholder's Sex _____

Group # _____ Policy # _____ Effective Date _____

Secondary Insurance Company _____

Insurance Address _____

Policyholder's Name _____

Policyholder's Birthdate _____/_____/_____ Policyholder's Sex _____

Group # _____ Policy # _____ Effective Date _____

Preferred Pharmacy

Name _____ Phone Number _____

Race _____

Ethnicity: Hispanic or Latino? Yes or No (please circle)

ASSIGNMENT AND RELEASE AND HIPPA:

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I also authorize the physician to release any information required to process this claim. I agree that this office may release records pertaining to my treatment including HIV and communicable diseases to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I understand the physicians in this office are independent corporations, not in association with one another. I acknowledge that I have received a copy of the Notice of Privacy Practices.

SIGNED _____ DATE _____/_____/_____

Which doctor do you see? ☐ Folkestad ☐ Austin