Welcome to Associates in Primary Care Medicine, Inc.

Welcome to our practice, how did you hear about us? _____

Patient Information

Name _____ Today's Date _____

Gender: **Male** **Female** Martial Status: **Married** **Single** **Divorced**

Date of Birth: _____

Address _____ **Widowed** **Living with partner**

_____ Social Security _____

Phone (Home)_____ (Work) _____ (Cell) _____

Race/Ethnicity _____

Primary Language Spoken _____ Primary Language Written _____

In case of emergency, please notify _____ Phone _____

Address _____

Relationship _____

Employment Information

Employer name _____ Occupation _____

Address _____

Phone _____

Medical Insurance

Primary Insurance _____ Policy # _____

Cardholder's Name _____ Date of Birth _____

Social Security # _____ Copay _____

Employer for Insurance Coverage_____

Secondary Insurance _____ Policy # _____

Cardholder's Name _____ Date of Birth _____

Social Security # _____ Copay _____

Employer for Insurance Coverage_____

Medical Information

Why are you seeing the doctor today? _____

_____

Did you injure yourself? _____ If so, what was the date? _____ First place treated _____

List any test(s) that have already been done _____

Attorney Name: _____ **Phone**: _____

Do you have any known drug allergies? ☐ Y ☐ N Drug _____ Reaction _____

Party Responsible for Payment (if not above or if patient is a minor)

Last Name _____ First Name_____ MI _____

Father/Guardian's Name _____ Mother/Guardian's Name _____

Date of Birth _____ Social Security _____

Street Address _____ City_____ State ____ Zip _____

Occupation _____ Work Phone _____ Email_____

Pharmacy

Name_____ Phone _____

"I authorize Associates in Primary Care Medicine, Inc., to furnish to my insurance carrier or other third-party payer the information about my diagnoses and treatment necessary to process claims for payment. **I acknowledge that Associates in Primary Care Medicine bills my third party payer as a service to me and that I am financially responsible for all charges that are deemed not covered or not medically necessary.** I am aware that separate services may be covered differently depending on my policy, which is my responsibility to understand. Interest, penalty, collection costs & legal costs incurred in order to obtain patient payment become the responsibility of the patient. I assign to Associates in Primary Care Medicine, Inc., all payments for medical services rendered. This assignment will remain in effect until I revoke it in writing. A photocopy of this assignment is as valid as the original."

Signature of responsible party: _____ **Date:** _____