

Family Healthcare Associates

Patient information:

1. _____
Last name First name M.I.

2. _____
Street address

City State Zip code

3. _____ 4. _____
D.O.B. Social security number

5. _____ 6. _____ 7. _____
Home Phone Work Phone Cell Phone

8. _____ 9. _____
Ethnicity Employment status (full, part time, retired, not working)

10. _____
Emergency contact name Phone number Relationship

Primary Insurance Information:

11. _____ 12. _____
Primary Insurance Policy Holder

13. _____ 14. _____ 15. _____
Policy Holder D.O.B. Sex Policy Holder Social Security Number

16. _____ 17. _____
Policy Holder Employer Policy I.D.

18. _____
Employer's Address

19. _____
Group Number

Secondary Insurance Information:

20. _____ 21. _____
Secondary Insurance Policy Holder

22. _____ 23. _____ 24. _____
Policy Holder D.O.B. Sex Policy Holder Social Security Number

25. _____ 26. _____
Policy Holder Employer Policy I. D.

27. _____
Employer's Address

28. _____
Group Number

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 Associate's Notice of Privacy Practices. Despite the risk that information transmitted electronically or through facsimile communications 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 communications devices. Additionally, I understand that some procedures/services performed by the physician 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.

Signature: _____

Printed Name: _____

Date: _____