

Today's Date ____/____/____

(Please Print)

PCP _____

PATIENT INFORMATION

Patient's Last Name			First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (Circle One)		
					<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married	<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name)			Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Street Address		City	State	ZIP Code	Social Security		Home Phone No. ()	
P.O. Box		City	State	ZIP Code				
Occupation		Employer				Employer Phone No. ()		
Chose Clinic Because/Referred to Clinic by (Please check one box) <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital								
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to Home/Work <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other								

Other Family Members Seen Here

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill		Birth Date / /	Address (if different)		Home Tel: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No				Email Address:		
				Consent for Email Communications: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Occupation	Employer	Employer Address			Employer Phone No. ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance <input type="checkbox"/> Aetna <input type="checkbox"/> BCBS <input type="checkbox"/> CIGNA <input type="checkbox"/> Humana <input type="checkbox"/> PHCS						
<input type="checkbox"/> SPHN <input type="checkbox"/> United <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid (Please provide coupon) <input type="checkbox"/> Other						
Subscriber's Name		Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						
Name of Secondary Insurance (if applicable)			Subscriber's Name		Group #	Policy #
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)		Relationship to Patient	Home Phone No. ()	Work Phone No. ()
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The above information is true to the best of my knowledge. I authorize the physicians of **Austin's Friendly Family Medicine, P.A. (AFFM)** to provide myself or my child with reasonable and proper medical care according to today's standards. I authorize the insurance company or any third party payer to pay any benefits due directly to this office should they accept assignment on my claim. I also authorize AFFM or the insurance company to release any information required to process my claims. I understand that AFFM has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to AFFM, I agree to forward to the clinic all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.**

X _____
PATIENT/GUARDIAN SIGNATURE

DATE