

WELCOME TO *INSIGHT FAMILY HEALTH CENTER*
PATIENT INFORMATION FORM

NAME (as shown on insurance card) _____ DATE _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH ___/___/___

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____ CELL PHONE _____

OCCUPATION _____ WORK PHONE _____

EMPLOYER _____ RELIGION _____

EMAIL _____ RACE _____

MARITAL STATUS _____ SPOUSE/GUARDIAN NAME _____

IN CASE OF EMERGENCY, PLEASE CONTACT _____

RELATIONSHIP _____ HOME# _____ WORK # _____

WHO IS RESPONSIBLE FOR PATIENTS ACCOUNT? _____

ADDRESS _____ HOME PHONE _____

PRIMARY INSURANCE _____

POLICY HOLDER'S NAME _____ RELATIONSHIP _____

HOW DID YOU HEAR ABOUT OUR OFFICE? (Please check all that apply)

- | | |
|---------------------------|-------------------------------|
| _____ BROCHURE | _____ SEMINAR |
| _____ NEWSPAPER | _____ RADIO – which station? |
| _____ TV – which station? | _____ PHARMACIST – which one? |
| _____ FRIEND/PATIENT | |
| _____ Name _____ | Address _____ |
| _____ OTHER _____ | |

I request payment of authorized Medicare or other benefits be made on my behalf to Insight Family Health Center for any services furnished to me by the medical provider. I authorize the release of medical information to the Health Care Financing Administration and its agents, including any information needed to determine these benefits or the benefits payable for related services.

I understand that all co-pays, deductibles or co-insurances are due at the time services are rendered unless prior arrangements have been made.

I understand that Insight Family Health Center will mail a “Thank-you” card to the person that I have indicated above as referring me to this practice.

SIGNATURE _____ DATE _____