FIRST CARE, P. C.

Patient's Name: _____
Last First Middle

Street Address: _____

Zip: _____ City: _____ State: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

SSN: _____ DOB: _____ Male: ____ Female: ____

Emergency Contact: Name: _____ Phone Number: _____

Patient Status: (*please circle*) Divorced Legally Separated Married Single Widowed

Employment Status: Full Time Part-time Not employed Retired Student

Patient's Employer: _____

Employers Address: _____

City, State, Zip: _____ Work Number: _____ Ext.: _____

Primary Insurance name: _____

Policy Holder's Name: _____

Policy Holder's Name: (*if different from above*) _____

Group Number: _____ Policy Number: _____ Effective Date: _____

Patient's Relation to Policy Holder: (*please circle*) self spouse child other

Policy Holder's Sex: (*please circle*) Male Female Policy Holder's Date of Birth: _____

Secondary Insurance Name: _____

Policy Holder's Name: (*if different from above*) _____

_____

Policy Holder's Employer: _____

Group Number: _____ Policy Number: _____ Effective Date: _____

Patient's relation to Policy Holder: (*please circle*) Self Spouse Child Other _____

Policy Holder's Sex: (*please circle*) Male Female Policy Holder's Date of Birth:

If minor, Please fill out Responsible party Information below.

Responsible Party Information: (*if other than patient*)

Name: _____ Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____

Assignment and Release: I hereby give authorization for my insurance benefits to be paid directly to First Care, P.C. I understand that I am financially responsible for all charges not paid for by insurance. I also authorize the release of any medical information to process my insurance claims. In the event of default, I agree to pay the cost of all collections and reasonable legal fees.

Signed: _____ Date: _____