PRIMARY CARE INSTITUTE

Today's Date: __/__/__

Name_____
Last First Middle
Date of Birth __/__/__ Age: __ Social Security# _____ Sex: ◊Male ◊Female

ADDRESS:

Mailing Address: _____
City State Zip
Home Phone: ( ) _____ Work: ( ) _____
Cell Phone: ( ) _____ e-mail: _____
Marital Status: ◊single ◊Married ◊Divorced ◊Widowed ◊Separated

PARENT, SPOUSE, OR RESPONSIBLE PARTY (IF DIFFERENT FROM PATIEN)

Name: _____ Date of Birth: __/__/__
Last First Middle
Address: _____
City State Zip
Home: ( ) _____ Work ( ) _____

INSURANCE COVERAGE-PRIMARY:

Insurance Co. Name: _____ Phone: ( ) _____
Address of Claim Center: _____
State Zip
Name of Policy Holder (Insured): _____
Policy Holder (Insured) Date of Birth: __/__/__ SS# _____Sex: ◊ Male◊ Female
Policy#: _____ Group Name or#: _____
Policy Type: ◊HMO ◊PPO
Employer Name: _____
Employer Address: _____
If patient is a child, check relationship: ◊Mother ◊Father ◊other _____

INSURANCE COVERAGE- SECONDARY:

Insurance Co. Name: _____ Phone ( ) _____
Address of Claim Center: _____
City State Zip
Name of Policy Holder (Insured): _____
Policy Holder (Insured) Date of Birth:__/__/__ SS#_____ Sex: ◊Male ◊Female
Policy#: _____ Group Name or#:_____
Policy Type: ◊HMO ◊PPO
Employer Name: _____
Employer Address: _____
If patient is a child, check relationship: ◊Mother ◊Father ◊other _____
EMERGENCY CONTACT_____ **PHONE:** ( ) _____

HOW DID YOU HERE ABOUT US: YELLOW PAGES, PHONE BOOK, WEBSITE, INSURANCE COMPANY, PATIENT, PHYSICIANS OFFICE, NEWSPAPER, OTHER