Internal Use Only

Other ID #_____ Initials _____

PRIMECARE FAMILY PRACTICE PATIENT INFORMATION FORM

Please complete this form in the entirety, including both front and back pages. Thank you

PATIENT

First Name | Middle Initial | Last Name | Preferred Name

Date of Birth | Age | Gender: M F | Marital Status: M S D W | Social Security Number

Race (optional)
_____ Asian _____ Black or African American _____ White
_____ American Indian or Alaskan Native
_____ Native Hawaiian or other Pacific Islander _____ Other

Ethnicity (optional)
_____ Hispanic or Latino
_____ Not Hispanic or Latino
Primary Language: _____

Patient Mailing Address | Apt # | City | State | Zip Code

CONTACT INFO

Home Phone ( ) | Work Phone ( ) Employer Name: | Cell Phone ( )

Please circle the preferred telephone number for communications (circle): Home Work Cell

Can we leave a message regarding results on your voice mail? Yes No Can we leave an appointment reminder on your voicemail? Yes No

E-mail Address (please print clearly):_____

RESPONSIBLE PARTY skip if same as patient

First Name | Middle Initial | Last Name | Nickname

Date of Birth | Age | Gender: M F | Marital Status: M S D W | Social Security Number

Mailing Address | Apt # | City | State | Zip Code

Insurance Information - Please present your insurance card so we may make a copy of it for your record.

PRIMARY INSURANCE

Insurance Company Name | Group Number | Insurance ID Number

Subscriber Name | Date of Birth | Subscriber Social Security Number | Subscriber Relationship to Patient

SECONDARY INSURANCE

Insurance Company Name | Group Number | Insurance ID Number

Subscriber Name | Date of Birth | Subscriber Social Security Number | Subscriber Relationship to Patient

Financial agreement and insurance assignment: I hereby authorize treatment by any PrimeCare Family Practice provider and/or affiliated medical staff member(s). I further authorize release of any/all medical charge information as is necessary for third party reimbursement from any insurance carrier, Tricare or Medicare. I authorize direct payment from the provided insurance to this practice. I accept responsibility for the payment of all charges incurred including co-payment, coinsurance, deductible, non-covered services with your specific plan, missed appointments, attorney's fees and any other collection related costs if necessary. If I have insurance that requires a specific primary care provider for payment, I understand that I may be responsible for charges incurred if the provider assigned is not at PrimeCare Family Practice. I understand it is my responsibility to notify PrimeCare Family Practice of any changes in health insurance coverage.

For Medicare Beneficiaries Only: I request that payment of authorized Medicare benefits be made on my behalf to PrimeCare Family Practice for any services furnished me by PrimeCare Family Practice. I authorize any holder of medical information about me to release to the Center for Medicare (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the CMS-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, PrimeCare Family Practice agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered or excluded services.

Signature of Patient/Responsible Party Relationship to Patient Date

Patient Name:_____ Date of Birth:_____

Pharmacy		
	Name	Phone number (incl area code)
	Location	

Additional Information

IMMEDIATE FAMILY MEMBERS SEEN HERE

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____

EMERGENCY CONTACT					
	First Name	Middle Initial	Last Name		Relationship to Patient
	Street Address	City	St	Zip Code	Phone number (incl area code)

RELEASE OF PROTECTED HEALTH INFORMATION

I authorize PrimeCare Family Practice to DISCUSS my health information with the following individuals:(A medical records release form will still be required to release actual copies of your medical records.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please check one of the following statements: I authorize: ☐ any/all information requested by the above parties OR

☐ the following specific information: _____

_____

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our practice consists of doctors and mid-levels, you must be willing to see mid-levels to be a part of our practice. Refusal to schedule with a mid-level will result in discharge from the practice.

HIPAA Acknowledgment:
Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. By providing your signature, you acknowledge that you have reviewed our notice before signing this consent. To obtain a personal copy of our Notice of Privacy Practices, notify the front desk staff.

_____ _____ _____

Signature of Patient/Responsible Party | Relationship to Patient | Dat