One Family medical group

PATIENT INFORMATION

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Today's date _____

Legal Name _____ Preferred Name _____ Phone _____

Date of Birth _____ Gender: ☐ F ☐ M ☐ O: _____ SS# _____

Preferred Pronouns *(select all that apply):* ☐ He/him ☐ She/her ☐ They/them ☐ Other: _____

Mailing Address _____

City _____ State _____ Zip _____

Email _____

Marital Status: ☐ Single ☐ Married / Partnered ☐ Widowed ☐ Other / It's complicated

Who may we thank for referring you? _____

EMERGENCY CONTACT

Name _____ Relationship _____

Address _____ Phone _____

RESPONSIBLE PARTY

If patient is the responsible party, check here: ☐

Name _____

Street Address _____

City _____ Relationship _____

SS# _____ Date of Birth _____ Age _____ Phone _____

INSURANCE *(Please present insurance card)*

Is cost a barrier to healthcare for you? ☐ No ☐ Sometimes ☐ Yes

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. Payment is to be made at time of service unless other arrangements have been made. ***Copayments are due at the time of service****. If you miss two scheduled appointments without notifying the office, there will be a missed appointment fee.*

Primary Insurance _____

Subscriber Name _____

Date of Birth _____ SS# _____

ID# _____ Group# _____

Subscriber's relationship to patient _____

Secondary Insurance _____

Subscriber Name _____

Date of Birth _____ SS# _____

ID# _____ Group# _____

Subscriber's relationship to patient _____

I have read and understood all of the above.

Signature _____ Date _____

Responsible party signature _____ Date _____

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