

Date: _____

Patient Information

Last Name: _____ First: _____ MI: _____ SS#: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Sex: _____ Marital Status: _____ Race: _____

Employer: _____ Occupation: _____

Employer Address: _____ Home Phone: _____

Work/Cell Phone: _____

Primary Insurance

Person Responsible for Account: _____ Relation to Patient: _____

Date of Birth: ____/____/____ SS#: _____ - _____ - _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Employer Address: _____ Phone: _____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name: _____ Relation to Patient: _____

Date of Birth: ____/____/____ SS#: _____ - _____ - _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Employer Address: _____ Phone: _____

In case of emergency, contact (someone who does not reside with patient)

Name: _____ Phone: _____

I certify that all of the information listed above is correct to the best of my knowledge, and that I, and/or my dependant(s), have insurance coverage with the company(ies) named above. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

North Putnam Family Healthcare may use my health care information and may disclose such information to the above named insurance company(ies) for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian

Date

Printed name of Patient, Parent, or Guardian

Relationship to Patient