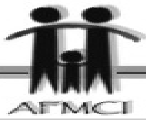

Acute Family Medicine Clinic

acutefamilymedicine.com

PATIENT INFORMATION

SOCIAL SECURITY # ______________________________

FIRST NAME ____________________ MIDDLE _________

LAST NAME ______________________________________

SEX ___________ DATE OF BIRTH __________________

MARITAL STATUS ☐ MARRIED ☐ SINGLE

☐ DIVORCED ☐ WIDOWED

(CHECK ONE) ☐ EMPLOYED ☐ RETIRED ☐ STUDENT

EMPLOYER ______________________________________

INJURY IS THE RESULT OF: AUTO ACCIDENT / WORK

MAILING ADDRESS ________________________________

____

CITY ________________ STATE ______ ZIP ____________

DRIVERS LICENSE # ______________________________

HOME PHONE ____________________________________

WORK PHONE ____________________________________

CELL PHONE _____________________________________

EMAIL ADDRESS __________________________________

PHARMACY ______________________________________

HOW DID YOU HEAR OF US? ____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other ____________________________

INSURANCE COMPANY ____________________________

SOCIAL SECURITY # ______________________________

CARD HOLDER'S NAME ___________________________

DATE OF BIRTH __________________________________

POLICY # ____________________________ GROUP # ________________________ PHONE # _____________________

SECONDARY INSURANCE INFORMATION

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other ____________________________

INSURANCE COMPANY ____________________________

SOCIAL SECURITY # ______________________________

CARD HOLDER'S NAME ___________________________

DATE OF BIRTH __________________________________

POLICY # ____________________________ GROUP # ________________________ PHONE # _____________________

EMERGENCY CONTACT

NAME ____ HOME # ________________________ WK # _______________________

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # ______________________________

RELATIONSHIP ___________________________________

FIRST NAME ______________________MIDDLE _________

LAST NAME _______________________________________

SEX __________ DATE OF BIRTH ____________________

WORK PHONE ____________________________________

EMPLOYER _______________________________________

MAILING ADDRESS ________________________________

CITY ______________________________ STATE __________ ZIP ____________________

I UNDERSTAND THAT MY PRIVATE INSURANCE WILL BE BILLED AS A *COURTESY*. IF, FOR *ANY REASON*, PAYMENT IS NOT RECEIVED WITHIN 30 DAYS OF THE APPOINTMENT DATE, I WILL BE ASKED TO PAY MY BALANCE IN FULL. I ALSO UNDERSTAND THAT SHOULD THIS DEBT BECOME DELINQUENT, THE BALANCE MAY BE REFERRED TO A PRIVATE COLLECTION AGENCY. I WILL BE HELD RESPONSIBLE FOR ALL FEES ASSOCIATED WITH THE COLLECTION OF MY DEBT. I UNDERSTAND THAT AFMCI HAS OPTED OUT OF THE MEDICARE PROGRAM, AND I MAY NEED TO SIGN A MEDICARE CONTRACT IF I HAVE COVERAGE WITH MEDICARE.

____ ____

PATIENT / RESPONSIBLE PARTY SIGNATURE **DATE**