Patient Profile

Please bring your insurance cards and a list of medications to all appointments.

Physician: ________________________________ Preferred Pharmacy/City: _____________________________

Last Name: ____________ First Name: ____________ Middle Initial: _____ Preferred Name:______________

Date of Birth: ____________ Sex: M F Social Security Number: __________________________

Race: __African Amer./Black __Amer. Indian/Alaskan Native __Asian __Caucasian/White __Nat Hawaiian/Pacific Islander __Other

Ethnicity: __Hispanic or Latino __Not Hispanic or Latino __Declined Primary Language: _______________

Marital Status: __ Single __ Married __ Widowed __ Divorced Other: ______________________________

Mailing Address: _______________________________ City: ________________ State: _____ Zip: ________

Home Phone: (___) _________________ Work #: (___) _________________ Cell #: (___) _________________

E-mail Address: __________________________ Preferred Method of Contact:__Phone __Mail __Patient Portal

Were you referred to our practice by another physician: __Yes __No If so, Name: _______________________

Primary Care Physician: ___________________________ Emergency Contact Phone #: ___________________

Insurance: **MUST PRESENT CARD AT TIME OF VISIT OR PAYMENT WILL BE REQUIRED IN FULL**

Primary Insurance: _____________________________ Policyholder/Name on Card: _______________________

Secondary Insurance: ___________________________ Policyholder: ___________________________________

Patient's Employer (if not applicable, insert "n/a"): ____

Spouse or Parent's Name: _____________________________________ Date of Birth: ____ / ____ / ________

Spouse or Parent's Employer: __________________________ Social Security Number: ___________________

ASSIGNMENTS OF BENEFITS

I request payments by Medicare, Medicaid, medical insurance companies and other third party payers be made payable to my healthcare providers. I authorize my physicians and healthcare providers to release my Protected Health Information (PHI) to the healthcare Financing Administration, insurance companies, and other providers of medical services as may be necessary to provide for my clinical care and/or to determine my financial benefits or coverages, in compliance with HIPAA and other applicable laws. I hereby acknowledge I have received a Notice of Privacy Practices. I understand and agree I am responsible for any charges not paid for by my insurance.

Signature of Patient or Legal Guardian: __________________________________ Date: __________________