Welcome to Associates in Family Practice

A division of Infinity Medical Group

Please Print & Fill Out Completely Cell Phone _____ Home Phone _____

Patient Name: _____ E-Mail Address _____
Last First MI

Date of Birth _____ Age_____ Sex: _____ Marital Status: _____ Soc. Sec. #_____

Address _____ City _____ State _____ Zip_____

Employer _____ Occupation _____ Phone _____

Referred by:_____ Allergies: _____

(Under 18)
Mother's/Wife's Name: _____ Social Security # _____
Last First MI

Address: _____ City _____ State _____ Zip _____

Phone: Home _____ Cell _____ Work _____ DOB_____

(Under 18)
Father's/Husband's Name:_____ Social Sec # _____
Last First MI

Address:_____ City _____ State _____ Zip _____

Phone: Home_____ Cell _____ Work _____ DOB _____

Insurance: _____ Phone _____ Through Employer Group? Y N

Policy Holder's Name _____ Relationship to Patient _____ DOB _____

Subscriber ID/Contract#:_____ Group #_____ Eff Date: _____

Policy Holder's Employer_____ Employer Phone #:_____

Secondary Insurance: _____ Phone: _____ Through Employer Group? Y N

Policy Holder's Name _____ Relationship to Patient _____ DOB _____

Subscriber ID/Contract#:_____ Group #_____ Eff Date: _____

Policy Holder's Employer_____ Employer Phone #:_____

Emergency Contact Name:_____ Relationship to Patient: _____

Phone Numbers: Home _____ Cell _____ Work _____

I hereby assign medical benefits due to me to be paid to Infinity Medical Group, d.b.a. Associates in Family Practice, P.C. I hereby consent to the release of medial information necessary to process any insurance claims and to any other doctor for continuation of my medical care. I understand that a photo copy of this release is as valid as the original.

Signature of Patient, Parent or Guardian _____ Date_____

PRIVACY POLICY: The undersigned Patient or Authorized Representative of the Patient acknowledges that he or she personally received a copy of the Infinity Medical Group, PLLC's (d.b.a. Associates in Family Practice, P.C.) Notice of Privacy Policies on the date indicated below.

Patient Name _____ Signature _____ Date _____

PERSONAL HEALTH INFORMATION: I hereby give my permission to Infinity Medical Group, PLLC, d.b.a. Associates in Family Practice, P.C. to disclose my P.H.I. to the personal representative(s) indicated below:

Name _____ Name _____ Name _____

Relationship_____ Relationship_____ Relationship_____