

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 _____

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 # _____

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Cell _____ Work _____ DOB _____

(Under 18)

Father's/Husband's Name

Social Sec # _____

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Cell _____ Work _____ DOB _____

InsurancePhone _____ 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 InsurancePhone _____ 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 _____