

# Welcome to Associates In Family Practice

## PLEASE PRINT

Today's Date \_\_\_\_\_ Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_

### PATIENT INFORMATION

Patient: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last First MI  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Gender: M F Marital Status: S M D W  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer Address \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
Who referred you to us? \_\_\_\_\_ E-Mail Address \_\_\_\_\_

### IF PATIENT IS A MINOR – RESPONSIBLE PARTY INFORMATION

Name \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_  
Last First  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Employer Address \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

### SPOUSE

Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer Address \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

### IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

### PRIMARY INSURANCE

Ins. Co. \_\_\_\_\_ Contract # \_\_\_\_\_ Group # \_\_\_\_\_  
Policyholder Name \_\_\_\_\_ Birth Date (required) \_\_\_\_\_ Eff. Date \_\_\_\_\_

### SECONDARY INSURANCE

Ins. Co. \_\_\_\_\_ Contract # \_\_\_\_\_ Group # \_\_\_\_\_  
Policyholder Name \_\_\_\_\_ Birth Date (required) \_\_\_\_\_ Eff. Date \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I assign directly to Associates in Family Practice, P.C. all benefits payable for services rendered. I authorize Associates in Family Practice, P.C. to release any information necessary to secure payment of said benefits and to use this signature on all insurance submissions whether manual or electronic. I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that presenting parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance and agree to make arrangements for prompt payment.

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 Associates in Family Practice, P.C.'s Notice of Privacy Policies on the date indicated below.

Patient Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

### PERSONAL HEALTH INFORMATION

I hereby give my permission to Associates in Family Practice, P.C. to disclose my P.H.I. to the personal representative(s) indicated below.

Name/Relationship \_\_\_\_\_ Name/Relationship \_\_\_\_\_

The undersigned verify an attempt was made to deliver a copy of the A.F.P.'s Notice of Privacy Policies to the above patient.

Signature \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_