PATIENT INFORMATION

DATE:_____ ACCOUNT #:_____

LAST NAME:	FIRST NAME:	MI:	
ADDRESS:	CITY:	STATE:	ZIP:
DATE OF BIRTH:	GENDER: ☐ Male ☐ Female	MARITAL STATUS: ☐ Single ☐ Married ☐ Widow ☐ Divorced	
HOME PHONE NUMBER:	EMAIL:	OTHER PHONE NUMBER / CELL PHONE NUMBER:	
SOCIAL SECURITY NUMBER:	DRIVERS LICENSE NUMBER:	SPOUSE'S NAME:	
PHARMACY: LOCATION: PHONE:		SPOUSE'S DATE OF BIRTH:	
EMPLOYER:		SPOUSE'S EMPLOYER:	
ADDRESS:		ADDRESS:	
CITY: STATE: ZIP:		CITY: STATE: ZIP:	
WORK NUMBER-EXT:		WORK NUMBER-EXT:	

GUARANTOR / RESPONSIBLE PARTY (IF DIFFERENT THAN PATIENT)

NAME:		DATE OF BIRTH:	SOCIAL SECURITY NUMBER:
ADDRESS:	CITY: STATE: ZIP:		☐Home ☐ Cell Phone
EMPLOYER:	ADDRESS: CITY: STATE: ZIP:		PHONE NUMBER:

EMERGENCY CONTACT

NAME:	RELATIONSHIP:	HOME PHONE:
ADDRESS: CITY: STATE: ZIP:		☐ Work ☐ Cell Phone:

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE CO.:	ADDRESS: CITY: STATE: ZIP:		PHONE NUMBER:
POLICY NUMBER OR MEMBER NUMBER:		GROUP NUMBER:	EMPLOYER:
NAME OF POLICY HOLDER:	DOB:	RELATIONSHIP (to policy holder): ☐Self ☐Spouse ☐Child ☐Other:	
ADDRESS: CITY: STATE: ZIP:			SOCIAL SECURITY NUMBER:

NAME OF SECONDARY INSURANCE CO.:	ADDRESS: CITY: STATE: ZIP:		PHONE NUMBER:
POLICY NUMBER OR MEMBER NUMBER:		GROUP NUMBER:	EMPLOYER:
NAME OF POLICY HOLDER:	DOB:	RELATIONSHIP (to policy holder): ☐Self ☐Spouse ☐Child ☐Other:	
ADDRESS: CITY: STATE: ZIP:			SOCIAL SECURITY NUMBER:

INSURANCE AUTHORIZATION AND ASSIGNMENT *(PLEASE READ AND SIGN)*

I HEREBY AUTHORIZE DEER PARK FAMILY CLINIC, P.A. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN DEER PARK FAMILY CLINIC P.A. ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE.

SIGNATURE: _____ **DATE:** _____

RELEASE OF MEDICAL RECORDS

I HEREBY AUTHORIZE DEER PARK FAMILY CLINIC, P.A. TO RELEASE INFORMATION FROM MY MEDICAL RECORD TO THE FOLLOWING INDIVIDUALS EFFECTIVE UNTIL (date)_____OR UNTIL 180 DAYS FROM THIS DATE.			
Name	Phone	Name	Phone
INFORMATION REGARDING HIV, CHEMICAL DEPENDENCY, OR SEXUAL TRANSMITTED DISEASES ☐**CAN** ☐**CANNOT** *BE RELEASED.*			

SIGNATURE: _____ **DATE:** _____