

PATIENT INFORMATION

Confidential Record: Information contained here will not be released without your permission. Please complete all information to the best of your knowledge. If you should have difficulty, please ask the secretary for assistance.

Last Name	First	Middle	Birth Date	Age
Mailing Address	City	State	Zip	Home Phone
Street / Road Address			Sex: Male <input type="checkbox"/>	Marital Status
			Female <input type="checkbox"/>	
If patient is a minor, parent or guardian's name			ACCIDENT INFORMATION:	
Employer / Address / Phone	Occupation	Social Security #	DATE _____	
			WHERE _____	
			HOW: _____	
			TIME: OF DAY: _____	
Do You Have Insurance?	If not, how do you intend to pay?		In case of emergency please contact:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cash	<input type="checkbox"/> Check <input type="checkbox"/> Credit Card	Relationship: _____ Phone # _____	
Insurance Company			Medicare # _____	
Insurance ID #			Medicaid # _____	
Does Your Insurance Company Require a Referral from Your Primary Care Physician?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Primary Care Physician Name _____		
Spouse's Full Name	Spouse's Employer & Address / Phone _____			
Social Security #				
Subscribers Full Name & Address (If different from above)				Subscriber ID # _____
Relationship to patient?				Date of Birth _____
				Group # _____
Whom may we thank for referring you?				

CONSENT FOR ASSIGNMENT OF BENEFITS

I authorize my insurance benefits to be paid directly to Jefferson ^{Primary Care}, realizing that I am responsible for non-covered services.

Signature of Patient or Guardian Date