Full Legal Name:_____ Nickname:_____

DOB:_____ Maiden Name(If applicable):_____ Marital Status: S M W D LBGT

Address:_____ City:_____ Zip:_____

Race:_____ Sex:____ Language: _____ SS#:_____

Preferred Contact Phone #:_____ Alternate Phone #:_____

Email: _____ Employer:_____

Spouse/Guardian Name:_____ Relationship to Patient: _____

****EMERGENCY CONTACT****

Name:_____ Phone:_____

Relationship to the Patient: _____

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Insurance Information: (Primary)

Name of Insurance Company:_____ Group #_____

Subscriber Name:_____ Subscriber SS#_____

Subscriber Address (if different than above):_____

Subscriber Phone:_____ DOB:_____ Relationship:_____

Subscriber Employer:_____ Work Phone:_____

Employer
Address:_____

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Insurance Information: (Secondary)

Name of Insurance Company:_____ Group #_____

Subscriber Name:_____ Subscriber SS#_____

Subscriber Address (if different than above):_____

Subscriber Phone:_____ DOB:_____ Relationship:_____

Subscriber Employer:_____ Work Phone:_____

Employer
Address:_____

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ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION:

I authorize payment of medical benefits to Apple Family Medicine for all services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the release of all information necessary to secure payment. I also understand that it is my responsibility to ensure that my physician is listed with my insurance company as my PCP (Primary Care Physician), otherwise I am responsible for any extra costs incurred. A photocopy of this assignment is to be considered as a valid as an original. This authorization for release of information includes faxing.

SIGNED:_____DATE:_____

****Please present your insurance card/photo ID. All copays are collected/due at the time of visit.****