Family Practice of CentraState

New Patient Forms/Patient Change Forms

Patient Information (Confidential)

Patient Name: _____ Date of Birth: _____ SSN _____Sex:_____

Home Phone #._____Cell Phone #_____ Email: _____

Enroll in our Patient Portal: (yes or no) _____ Marital Status:
_____

Home Address: include City, State, Code: _____

Emergency Contact (name, relationship, and phone #) _____

Pharmacy Name and phone number: _____

Primary Care Provider: _____Occupation:_____Employer's Name: _____

Please check appropriate field below:

Ethnicity: Hispanic/Latino__ Not Hispanic or Latino___ Unknown/refused___

Race: ___White ___African American/Black

___Asian ___Other Pacific Islander/ Native Hawaiian

___ American Indian/Alaskan Native ___Indian

___More than one race ___Unknown/refused

Guarantor Information (Party Responsible for Payment of Personal Balance) Self: _____ < (mark an X)

Patient Relationship to Guarantor_____

Guarantor Name_____ Address_____

City, State/Zip Code_____ Guarantor SSN: _____

Guarantor Phone No_____ Guarantor Birthdate_____ Sex_____

PRESENT INSURANCE CARD, CO-PAY AND PHOTO ID TO THE FRONT DESK AT TIME OF VISIT.

ASSIGNMENT OF BENEFITS: I ,hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance, and any other health Plans to Family Practice of Centrastate.,. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature: _____Date: _____