PATIENT INFORMATION

(Please print)

Patient's Last name:	First:		Middle:	
Marital status (circle one): Single / Married	Social security no:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:				Home phone: ( )
City:	State:	ZIP Code:		Cell phone: ( )
Race: ❑ Vietnamese ❑ Hispanic ❑ White ❑ African-American ❑ Other:_____		Ethnicity: ❑ Nonhispanic ❑ Hispanic	Language Preference: ❑ Vietnamese ❑ Spanish ❑ English ❑ Other: _____	
Emergency Contact:	Relationship to patient:		Phone: ( )	
Email:				
Preferred pharmacy phone: ( )		Pharmacy fax: ( )		

INSURANCE INFORMATION

Please indicate primary insurance	❑ Aetna	❑ Amerigroup/Medicaid	❑ BCBS	❑ Humana	❑ Memorial Hermann
	❑ CHC	❑ United HealthCare	❑ Cigna	❑ Selfpay	❑ Other: _____

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /
Policy number:	Group number:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑Other: _____		

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above named insurance. I assign directly to <u>PROVIDENCE FAMILY PRACTICE, P.A.</u> all insurance benefits, if any, otherwise payable to me for services rendered. *I understand that I am financially responsible for all charges, whether or not paid by insurance.* All fees will be paid at the time of service unless other arrangements are made in advance. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ (Initial) I have reviewed the HIPAA privacy practice form and give my permission to Providence Family Practice to use or disclose my health information in accordance with the guidelines of HIPAA regulation.

_____(Initial) I have reviewed all clinic policies given to me. I understand and agree to abide by all clinic policies.

_____ _____ _____

Patient/Guardian Signature ***Relationship*** ***Date***