SETZER
personal physicians

Patient Information Form

Date:__________________

Patient Name___________________________________ Date of Birth__________ Age________

Social Security # ________________________

Address__________________________________ City/State/Zip_______________________________

Telephone______________________ Cell____________________Email __________________________

Other family members living at this address:____

Marital Status: Single__Married___Spouse's Name_________Divorced___ Widowed___ Separated____

Employer:_______________________Work Number: ___________________ Ext:_______ Other:______

Emergency Contact:______________________________ Relationship:___________________

Contact Telephone#s: Home: ____________ Cell____________ Work _____________ Ext:_______

May we leave a message regarding your medical care at your home? Yes/No

On your cell phone voice mail? Yes/No On your work voice mail? Yes/No

If patient is a minor (under 18 years of age), please complete the following:

Mother's Name:______________________ ________ _______________________________

First M.I. Last name-if different from above

Telephone #'s: Home__________________ Cell______________ Work_____________ __ Ext:_______

Email:_______________________________

Father's Name: _______________________ _______ ________________________________
First M.I. Last name- if different from above

Telephone #'s: Home_________________ Cell_____________ Work_____ __________ Ext:________

Email:_______________________________

Who has legal custody of the patient? Both Parents____ Mother ____ Father _____Guardian______

If guardian complete the following: Name ______________________________

Address: _________________________________ City/State/Zip_________________________

Telephone #'s: Home__________________ Cell ___________ Work ________________ Ext:________

Referred by: ________________________________ Former Doctor___________________________

Have you had information from another Dr./Facility forwarded to this office? Yes____ No____

If yes, who from? _________________________________

Reason for transferring your care: Relocation_____ Insurance______Accessibility_____Other_________

Do you have insurance? Yes____ No______ If yes , complete the following insurance/billing information:

Primary Insurance:______________________ID#:______________ Group#:___________________

Insurance Company Name: ___________________________________

Subscriber: ______________________________ Relationship to Subscriber: ________________

Subscriber's Date of Birth:______________________ Subscriber's SS#: ____________________

Secondary Insurance: ____________________ ID#: _____________ Group#: __________________

Insurance Company Name: ___________________________________

Subscriber: _____________________________ Relationship to Subscriber:__________________

Subscriber's Date of Birth: ______________________ Subscriber's SS#: ____________________

Guarantor: (Person responsible for co-payments and for charges which are NOT covered by insurance)

Guarantor's Name: __________________________ Guarantor's SS#: _________________________

Address (required for accurate billing):____

AUTHORIZATION:

I hereby authorize Setzer Personal Physicians to furnish information to any insurance carriers concerning my medical, and I hereby irrevocably assign Setzer Personal physicians any payment for services rendered.

I understand that I am responsible for all charges whether or not covered by insurance.

I certify that this information is accurate as of this date.

SIGNATURE:____ Date : ____________________