PATIENT INFORMATION

DATE: _____

PATIENT'S NAME _____ **DATE OF BIRTH** _____
Last First Middle

( ) Child **( ) Unmarried** **( ) Married** **( ) Separated** **( ) Widowed**

ADDRESS _____
Number & Street City State Zip

SOC SEC # _____ **SEX ( ) MALE** **( ) FEMALE**

PHONE _____ **CELL PHONE** _____

Email _____ **PREFERRED METHOD CONTACT: ( ) LETTER** **( ) PHONE CALL** **( ) EMAIL**

EMPLOYER _____
Name Address Telephone #

EMERGENCY CONTACT _____
Last First Telephone #

RACE: HISPANIC ASIAN CAUCASIAN BLACK AFRICAN AMERICAN NATIVE AMERICAN CHINESE FILIPINO JAPANESE NATIVE HAWAIIAN MULTIRACIAL PACIFIC ISLANDER AMERICAN INDIAN or ALASKA NATIVE OTHER

ETHNICITY: HISPANIC or LATINO NON HISPANIC or LATINO OTHER or UNDETERMINED

LANGUAGE: ENGLISH FRENCH GERMAN VIETNAMESE ITALIAN MANDARIN SPANISH

( ) PARENT'S OR SPOUSES NAME _____
Last First Middle

( ) PARENT'S OR SPOUSE'S EMPLOYER _____
Name &Address Telephone #

RESPONSIBLE PARTY FOR ACCOUNT

NAME _____ **DATE OF BIRTH** _____
Last First Middle

ADDRESS _____
Number & Street City State Zip

SOC SEC # _____

PHONE _____ **CELL PHONE** _____

EMPLOYER _____
Name & Address Telephone #

INSURANCE INFORMATION

PRIMARY _____
Company GROUP # ID #

HOLDER OF INSURANCE _____
Last First MI DOB SS #

ANY OTHER INSURANCE _____
Company GROUP # ID #

HOLDER OF INSURANCE _____
Last First MI DOB SS #

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I do hereby consent to the provision of health care services by the staff of Babson & Associates Primary Care P.C.

I authorize Babson & Associates Primary Care P.C. to use and disclose any & all medical information to any facility, insurance company, or entity pursuant to the coordination of care. I assign all insurance payments to Babson & Associates Primary Care P.C.

I have read and understand the following financial obligations:

- I am responsible for providing proof of insurance and photo ID at the time of service.
- Copays, deductibles, or any other cost share are due at the time of service.
- I understand that some of the services I receive may not be covered by my insurance and that I am responsible for all charges on my account.
- I understand that accounts with balances over 30 days old are considered past due and if monthly payments are not received the account may be placed in a collection status or ultimately referred to a collection agency. No appointments will be made for any account in a collection status, and I will incur all costs of collection, including but not limited to collection agency fees and court costs.
  I understand that **I** will be responsible for all fees related to dishonored checks, minimum of $30.00.
- I understand that if I do not cancel appointment 24 hours in advance that $25.00 will be charged to your account and this charge will not be billed to your insurance. This fee covers administrative tasks associated with your appointment.

I have read and understand the following privacy practices:

- I have the right to review the Notice of Privacy Practices prior to signing the consent, and a written copy is available upon request.
- I may revoke my consent in writing at any time.
- Babson & Associates Primary Care P.C. reserves the right to revise its Notice of Privacy Practices at any time. Please contact our office for the most current Notice.

Our practice is committed to providing the best treatment and service to our patients. Thank you for choosing us as your primary care provider.

SIGNATURE_____**Date:** _____
Responsible Party

Important Medical Information

Name _____ **DOB** ____/____/____

Address _____

Family History: If any blood relative has suffered any of the following - please indicate which relative.

( ) Diabetes _____ ( ) Thyroid disease _____

( ) Heart disease _____ ( ) High blood pressure _____

( ) Cancer _____ ( ) Other _____

Major Illnesses or operations and year: _____

Smoker ( ) Yes ( ) No

Medications patient is taking _____

Chronic medical conditions: _____

Allergies patient may have: _____

Name _____ **DOB** ____/____/____

	Medication	Dose	Direction	Prescribing Provider other than Babson & Assoc	Pharmacy
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

	Health History: Diagnosis / Surgeries	Date of onset / Surgery
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

	Allergies: Medication / Food	**Reaction:** rash, hives, itching, nausea fatigue, difficulty breathing, swelling face, eyes, anaphylaxis
1		
2		
3		
4		