DRAVES FAMILY MEDICINE

Patient Information Form

Name: _____ Sex: male / female Date of birth: _____

Address: _____ City _____ State: _____ Zip _____

Home Phone: _____ Cell Phone: _____

Social Security No: _____ Marital Status: single / married / divorced / widowed

E-mail: _____

Employer: _____ Business Phone: _____

Responsible Party (who statements are addressed to)

Name: _____ Relationship to patient: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone : _____

Employer: _____ Business phone: _____

Insurance

It is YOUR responsibility to present your Insurance Card to the receptionist on every visit. If you do not present your updated insurance card or if you give us an incorrect insurance card and the claim is denied by the insurance, the patient will be responsible for any outstanding balance. WE WILL NOT RE-FILE THE CLAIM FOR YOU.

Primary Insurance: _____ Secondary Insurance: _____
Coverage through: _____ Coverage through: _____
Relation to Patient: _____ Relation to Patient: _____
*Card holder DOB: _____ *Card holder DOB: _____
Insurance ID # _____ Insurance ID # _____
Group # _____ Group # _____
Co-pay $ _____ Co-pay $ _____
*needed to file claim if other than the patient

I hereby authorized release of information necessary for my insurance company to process my claim. The above Information is correct to the best of my knowledge. I hereby authorize payment directly to Draves Family Medicine's insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid in a timely manner by my insurance.

Emergency contact

Name: _____ Relationship to patient: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone : _____

Pharmacy Information

Local Pharmacy: _____ Location: _____

Phone No: _____

Mail Order Pharmacy: _____ Phone: _____