FAMILY FIRST MEDICINE

PATIENT INFORMATION

Name: ________________________________Date of Birth:_____/_____/_____ Age: ____ Sex_____

SSN: ______________________________ Home Phone: (______)__________________________

Cell Phone: (_____) __________________ E-Mail:____

Address: ____ Nick Name: ____________

City: _____________________ State: ____________ Zip Code: _______________________

Employer: ______________________________ Work Phone :(_________) _________

Employer Address: ____

INSURANCE INFORMATION-PRIMARY INSURANCE INFORMATION

Subscriber Name: __________________________________ Subscriber DOB: ___________________

Policy #:__________________________________ Group #_______________________________

Subscriber SSN: ______________________________ Relation to Patient:_______________________

Subscriber Employer: _________________________ Insurance Co. Name: _____________________

Effective Date of Insurance: _________________________

SECONDARY INSURANCE INFORMATION

Subscriber Name: __________________________________ Subscriber DOB: ___________________

Policy #:__________________________________ Group #_______________________________

Subscriber SSN: ______________________________ Relation to Patient:_______________________

Subscriber Employer: _________________________ Insurance Co. Name: _____________________

Effective Date of Insurance: _________________________

PLEASE INCLUDE COPY OF INSURANCE CARD FRONT AND BACK

I agree to promptly pay for the services rendered for me or the patient named above. I authorize Family First Medicine to test my blood for hepatitis and/or HIV if in their opinion an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration. INSURED or AUTHORIZED PERSON"S SIGNATURE: I authorize payment of medical benefits directly to Family First Medicine on my behalf for services rendered.

Signature:____ Date:_________________