Family Practice Physicians

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New Patient / Update Information

Patient Name:_____

Patient Mailing Address:_____

Patient Physical Address:_____

City:_____State:_____Zip:_____

Home Phone:_____ Work Phone:_____ Cell: _____

Email:_____Preferred contact method:_____

Patient Social Security #:_____Date of Birth:_____

Sex: Male Female Is the patient a minor? Yes No

If yes, please provide information for parent or guardian:

Name:_____

Social Security #:_____

Date of Birth:_____

Address same as patient? Yes No

If no, please provide address for parent or guardian: _____

Race:
☐ American Indian ☐ AK Native ☐ African American
☐ Hispanic ☐ White ☐ Asian ☐ Hawaiian
☐ Other Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic/Latin ☐ Not Hispanic/ Latin

Preferred Language:_____

Who may we contact in case of an emergency?_____

Home Phone:_____Work Phone:_____

Relationship to Patient:_____

Insurance Information

(Please provide insurance card(s) to receptionist)

1. Primary Insurance Company Name:_____

   Insurance holder:_____

   Relationship to patient :_____ Date of Birth :_____

2. Secondary Insurance Company Name:_____

   Insurance holder:_____

   Relationship to patient :_____ Date of Birth :_____

I authorize the release of any medical or other information necessary to process my claims. I also request payment of medical benefits or government benefits to Family Practice Physicians.

Patient's or authorized person's signature:_____Date:_____