MITCHELL FAMILY MEDICINE

PATIENT INFORMATION					❑ ***New Patient*** ❑ ***Established PT***
Patient's FIRST Name: MIDDLE: LAST:					Social Security #:
Birth date: / /	Sex: ❑ M ❑ F	Marital status (circle one) Single / Mar / Div / Sep / Wid	Employment Status (circle one) Employed / Retired / Student / Not-Employed		EMPLOYER NAME:
Your Address:			City	State:	Zip Code:
Race: ❑Decline ❑White ❑American Indian /Alaska Nat. ❑Asian ❑Black/African American ❑Nat.Hawaii/Oth Pac Islander ❑Other			Ethnic Group: ❑Non-Hispanic ❑Hispanic/Latino ❑Decline		Language: ❑English ❑Spanish ❑Other:_____
Primary Phone#: ❑ Cell ❑ Work ❑Home ( )		Alternate Phone#: ❑ Cell ❑ Work ❑Home ( )		Email Address: Appointment reminder by email? ❑ Yes ❑ No	
EMERGENCY/HIPAA CONTACT: NAME AND PHONE #					
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RESPONSIBLE PARTY:		
SELF UNLESS PATIENT IS A MINOR	Guarantor's Full Name:	Patient's Relationship to Guarantor: ❑ Child ❑ Spouse ❑ Other:
Address (if different):	Birth date: / /	Social Security #:

INSURANCE INFORMATION:			
Primary Insurance Company Name:	Plan Name:	Type of Plan: ❑ PPO ❑ POS ❑ HMO ❑ Medicaid ❑ Medicare ❑Tricare ❑ Medicare HMO ❑ WC ❑ Lien	
Claims Address:			Phone#: ( )
Policy#:	Group #:	Group Name:	
Secondary Insurance Company Name:	Plan Name:	Type of Plan: ❑ Medicare Supplemental ❑ Medicaid ❑ Other Employer/Commercial ❑ Spouse's Plan (Pls. complete guarantor section) ❑ Other:	
Claims Address:			Phone#: ( )
Policy#:	Group #:	Group Name:	
Is plan thru employer? ❑ No ❑ Yes	Employer Name & Address:		

ACKNOWLEDGEMENT:

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in this clinic's Notice of Privacy Practices. I authorize my insurance benefits be paid directly to MITCHELL FAMILY MEDICINE as indicated on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage.

Patient/Guardian signature: Date