Welcome to Associates in Family Practice, PLLC <u>Please Print & Fill Out Completely</u>

TODAY'S DATE	Referred by						
Patient Name Las	ıt	First		MI	Date of Birth		
Social Security #			Male F		Marital Status: S M	I D W	
Race	Ethnicity Hispanic or	Latino or NO	ON Hispani	ic or Latino	Language		
Address					State	Zip	
Home Phone	Cell Phone _			Prefe	erred Contact # Cell H	ome Work	
E-Mail Address			Allergi	es			
Employer	Occ		upation		Phone		
If Patient is Under 18 Responsible Party/or Spouse				·····	Soc Sec #		
Address							
Phone Home	Cell			_ Work	DO)B	
Insurance Company				Ph	one		
Policy Holder's Name	Relationship			ip to Patient _	DO	DOB	
Subscriber ID/Contract#		Group #			Effective Date		
Policy Holder's Employer				_ Employer	Phone #		
Secondary Insurance				P	hone		
Policy Holder's Name		Relationshi		ip to Patient _	ient DOB		
Subscriber ID/Contract#		Group #		Effective Date			
Policy Holder's Employer				_ Employe	r Phone #		
Emergency Contact Name #1_				Relationship to Patient:			
Phone Numbers Home	Cell		Work				
Emergency Contact Name #2				Relatio	nship to Patient		
Phone Numbers Home		Cell		Work			
PERSONAL HEALTH INFOI personal representative(s) indica		ve my permis	sion to Ass	ociates in Fa	mily Practice, PLLC to dis	close my P.H.I. to the	
Name	Name	Name		Name			
Relationship	Relationsh	Relationship		Relationship			
Signature	Date	Rev	vised - Sigr	nature	Γ	Date	
ASSIGNMENT OF BENEFITS: I hereby assign medical benefits information necessary to process copy of this release is as valid as	s due to me to be paid to s any insurance claims ar						
Signature of Patient, Parent or		Date					
PRIVACY POLICY : The und copy of Associates in Family Pra	ersigned Patient or Authoractice, PLLC's Notice of	orized Represe Privacy Polici	entative of ies on the d	the Patient ac late indicated	cknowledges that he or she below.	personally received a	

Signature ____