PRIMARY MEDICAL CARE

PATIENT INFORMATION

Last Name _____**First Name** _____**Middle Int.** _____

Street Address _____**Apt #** _____**City** _____**State** _____ **Zip**_____

Sex _____**Employed** ☐ Yes ☐ No **Employer/School** _____

Best Telephone Number to Call: Home Phone _____ **Cell Phone #** _____

Date of Birth _____**SSN #** _____ **E-Mail Address** _____

Spouse _____ **Cell Phone #** _____

Spouse's Employer _____**Address** _____**Phone #** _____

Parent/Guardian _____**Address** _____**Phone #** _____

Nearest Relative/Friend _____**Home Phone #** _____**Cell Phone #** _____

Pharmacy Name_____ **Pharmacy Phone #** _____

How did you hear about out office? Ins. Carrier _____ **Ad- Where?**_____ **Another Patient/Family Member-Name**_____

INSURANCE POLICY HOLDER INFORMATION

(You must provide an insurance card for verification purposes.)

PRIMARY INSURANCE:
Are you the Policy Holder? ☐ Yes ☐ No (If not please complete below information)
Please check: ☐ Spouse ☐ Dependent.
Insurance: Aetna ☐ BCBS ☐ Cigna ☐ Medcost ☐ PHCS ☐ United Healthcare ☐ No Insurance ☐

Policy Holder Last Name _____**First Name** _____**Middle Int.**_____

Street Address _____**Apt #** _____**Cit y**_____ **State** _____**Zip**_____

SSN # _____**D.O.B**_____ **Employer** _____

Policy ID # _____**Group #** _____ **Effective Date** _____

SECONDARY INSURANCE: ***We do not file secondary insurance*.**

Consent for Treatment: The undersigned hereby consents to examination and treatment of the patient by the physician(s) and to the performance of any surgical or diagnostic procedure, which is deemed necessary including HIV testing.

Authorization to Release Information: I hereby authorize the release of medical information necessary for the purposes of determining eligibility for payment of insurance benefits or to a physicians office to which I have been referred to as a result of my care at this facility.

Laboratory Consent: We use LabCorp here on site for any laboratory/blood work. These are separate entities and are not associated with Primary Medical Care. Each patient is responsible for checking with his/her insurance plan to see if these services are covered under his/her insurance plan. You are not obligated to use LabCorp for your labs but if you choose to do so, you may receive a separate bill from LabCorp for any non-covered services. ***All billing questions must be directed to these companies*.**

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE
We accept Cash, Checks, Visa, Discover, MasterCard & American Express

Patient/Parent Signature _____ **Date** _____