PRIMARY MEDICAL CARE

PATIENT INFORMATION

Last Name ______________________________________**First Name** ______________________________**Middle Int.** _________

Street Address ______________________________**Apt #** _______**City** ______________**State** ___________ **Zip**_____________

Sex _______**Employed** ☐ Yes ☐ No **Employer/School** ____

Home Phone ___________________**Work Phone** _______________________**Cell Phone #** ____________________________

Date of Birth _____________**SSN #** ________________________ **E-Mail Address** ____________________________________

Spouse ______________________________**Work Phone #** _________________________**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** ________________________________