PATIENT INFORMATION
Please print clearly and complete all blanks

DATE:______________________REFERRED BY:____SEX:________________

NAME:____BIRTHDATE:_______________________
LAST FIRST MIDDLE

MAILING ADDRESS:____
CITY STATE ZIP

TELEPHONE:_______________________CELL PHONE:_______________________WORK NUMBER:____________________

SS #________________________MARITAL STATUS:__________EMAIL:____

EMPLOYER:______________________________________OCCUPATION:____

EMPLOYER'S ADDRESS:____
****

RACE (circle one): AMERICAN INDIAN – ALASKAN – ASIAN – BLACK – WHITE – HISPANIC

SMOKER STATUS (circle one): EVERY DAY – SOME DAYS – FORMER – NEVER

RELIGION:____
****

NEXT OF KIN:____BIRTHDATE:_______________________

ADDRESS IF DIFFERENT:____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:____________________MALE________FEMALE_____________TELEPHONE:_________________________
****

EMERGENCY CONTACT:____

ADDRESS IF DIFFERENT:____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:____________________MALE________FEMALE_____________TELEPHONE:_________________________
****

RESPONSIBLE PARTY FOR BILLING (if other than patient):

NAME:____RELATIONSHIP TO PATIENT:______________________

ADDRESS:____
ADDRESS CITY STATE ZIP CODE

SS #:________________________BIRTHDATE________________________________TELEPHONE:_____________________
****

PRIMARY INSURANCE:____________________________ID#:________________________GROUP#_____________________

NAME OF INSURED:____INSURED'S BIRTHDATE:___________________

SECONDARY INSURANCE:_________________________ID#________________________GROUP#______________________

NAME OF INSURED:____INSURED'S BIRTHDATE:___________________

All professional services rendered are charged to the patient's account. Necessary forms will be completed to expedite insurance claims for those plans which the physician files. The patient is responsible for all fees, regardless of insurance coverage.

I hereby assign to the physician all payments for medical services rendered and authorize the physician to release any medical information necessary to process claims and request payments from insurance companies or Medicaid payers. A photocopy of this assignment and authorization shall be considered as valid as the original.

REV 2017.03.28 FORM#:TCH_FGMC005.11.ai

SIGNATURE:____DATE:_________________________________

MEDICATION SUMMARY

PATIENT ____ DOB _____/_____/_____

PHARMACY __________________________________PHARMACY PHONE # ______________

ALLERGIES ____

____

START DATE	MEDICATION/STRENGTH	DIRECTIONS	PRESCRIBED BY