An affiliate of Saint Mary's Health System

PLEASE FILL OUT ALL SECTIONS OF THIS FORM. ACCURACY IS VITAL FOR PROPER INSURANCE SUBMISSION.

Name: ____Today's Date: ___________________

First Middle Last

Home Address: ____

City: __________________________________ State: _________ Zip: _______________

Telephone: ( ) ___________________ Birthdate: _________________ Age: _______

Email Address: ___________________________________ (for use of patient portal only)

Marital Status: __Single __Married __Divorced __Widowed

Occupation: _____________________________________ SSN: ___________________________

Employment status: __Employed __Unemployment __Retired

Employer: ____ Years There: _____________

Employer's Address: ____

City: __________________________________ State: _________ Zip: _______________

Work Phone: ( ) ________________________________

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: ____________________________________ Relationship to Patient: ________

Home Address: ____

City: __________________________________ State: ___________ Zip: ______________

Telephone: ( ) ______________________ Birthdate: ___________________ Age:_______

Occupation: ____ SSN:________________________

Employer: ____ Years There: _____________

Employer's Address: ____

City: __________________________________ State: _________ Zip: _____________

Work Phone: ( ) ________________________________

In case of emergency, contact: ______________________________ Relationship: __________

Home Phone: (   ) ________________________   Work Phone: (   ) ____________________

May we give Medical information to a spouse or other party if you are not available? If so, please give us a name.

____Date:__________________________

How did you learn about our practice? ____

Insurance Information

Patient's Name:____ Today's Date:__________

First   Middle   Last

[Primary Insurance]

Name of Insurance Company:

____

Address: ____

City: ________________________________   State: _________   Zip: ______________

Insured's Name: ____

Group Number: ________________________   Policy ID Number: ____________________

[Secondary Insurance]

Name of Insurance Company:

____

Address: ____

City: ________________________________   State: _________   Zip: ______________

Insured's Name: ____

Group Number: ________________________   Policy ID Number: ____________________

Signed: ____________________________   Date: ____________________

(Patient or responsible party)