PATIENT INFORMATION

NAME: (Last) _____ (First) _____ (Middle) __ SS#_____

ADDRESS: _____City: _____ State: _____ Zip Code: _____

PHONE: _____ (Cell Phone #) **Email:** _____

DATE OF BIRTH: _____ **Sex**: Male ____ Female ____

Race: Asian ____ Black ____ Hispanic ____ White ____

Language: English ____ Other ____ Sign Language ____ Spanish ____

Ethnicity: Latino: YES ____ NO ____

MARITAL STATUS: Single ____ Married ____ Widowed ____ Divorced ____

EMPLOYER: _____ Phone #: _____

PHARMACY: _____ (Phone #) _____

EMERGENCY CONTACT (Name): _____ Relationship: _____

Phone #: _____

GUARANTOR / RESPONSIBLE PARTY (If same, write same as above)

PRIMARY SUBSCRIBER'S INFO (Whose name insurance is in)

Name: _____ SS#: _____

Relationship: _____ Sub. D.O.B: _____

Address: _____

City: _____ State: _____ Subscriber's Phone #: _____

SECONDARY SUBSCRIBER'S INFO

Name: _____ SS#: _____

Relationship: _____ Sub. D.O.B: _____

Address: _____

City: _____ State: _____

IS THIS VISIT RELATED TO AN INJURY? NO ____ YES ____ AUTO ____ WORK ____

I assign all medical benefits to which I am entitled to TOTAL PATIENT CARE, LLC. I understand that I am financially responsible for charges incurred that are not covered by my insurance. I authorize said assignee to release any information needed to determine these benefits payable for related services.

Patient Signature: _____ Date: _____