Primary PartnerCare®

Primary PartnerCare Physicians, PLLC

Last Name_____First Name_____MI _____

Date of Birth _____ SSN _____

Home Address_____
Street *City* *State* *Zip*

Mailing Address (if different)_____
Street *City* *State* *Zip*

Home Phone _____ Mobile Phone _____ Work Phone _____

Email address: _____

Please Circle from the Answer Choices Below:

Text Messages:	**Phone Calls:**	**Preferred Contact Method:**
Do you agree to receive automated texts messages from our Care Center? Yes No	Do you agree to receive automated phone calls from our Care Center? Yes No	Home Phone Work Phone Mobile Phone Mail
Primary Language: English Spanish Other _____ Decline to Specify **Do you need an Interpreter?** Yes No	**Race:** White Black/African-American Asian American Indian/Alaskan Native Native Hawaiian/Other Pacific Islander Decline to specify	**Are You:** Hispanic/Latino Not Hispanic/Latino Decline to specify

Please Circle from the Answer Choices Below:

Marital Status:	**Assigned Sex at Birth:**	**Gender Identity**:	**How did you hear about us?**
Married Single Divorced Separated Widowed Life Partner	Male Female	How do you identify yourself? Male Female Other _____	Doctor/Specialist:_____ Hospitalist:_____ Health Plan Direct Health Plan Website Employer Friend Family Urgent Care Hospital Our Website Web Search ZocDoc Health Grades Lawyer Accountant

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Person to contact in case of emergency

Name_____

Relationship to patient _____Home#_____Mobile # _____

Next of Kin

Name _____ Relationship _____ Phone # _____

Employment Information:

Employer Name:_____

Employer Address _____

Street *City* *State* *Zip*

Employer Phone #: _____ Occupation: _____

Financially Responsible person: (if different from patient or if patient is minor)

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____Relationship to patient _____

Address_____

Street *City* *State* *Zip*

Phone # _____ Email _____

MEDICAL INSURANCE INFORMATION (Primary Insurance)

Name of Insurance _____

Member ID number_____Policy/Group # _____

Patient's Relationship to Policy Holder _____

Policy Holder Last Name_____Policy Holder First Name_____

Address of insured (if different from patient) _____

Street *City* *State* *Zip*

Date of birth _____Sex (Male or Female) _____

Employer_____

SECONDARY INSURANCE INFORMATION

Name of Insurance _____

Member ID number_____Policy/Group # _____

Patient's Relationship to Policy Holder _____

Policy Holder Last Name_____Policy Holder First Name_____

Address of insured (if different from patient) _____

Street *City* *State* *Zip*

Date of birth _____Sex (Male or Female) _____

Employer_____

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Reason for Visit _____

Allergies to Medications _____

Pharmacy Name_____

Pharmacy Address _____

Street *City* *State* *Zip*

Signature on File: By signing below, I

- Authorize use of this form on all on my insurance submissions.
- Authorize release of information to all of my insurance companies.
- Authorize my health care provider to act as my agent in helping obtain payment from my insurance company.
- Authorize payment directly to my healthcare provider(s).
- Permit a copy of this authorization to be used in place of the original.
- Understand that I am responsible for my bill, including any copays, deductible, or coinsurance.
- Understand that if my health care providers accept assignment, I am responsible for any amount not paid by my insurance company, which may include any non-covered services.
- The information I have given this office is true and complete to the best of my knowledge. I hereby authorize the doctors and staff of Primary PartnerCare Physicians, PLLC to administer such procedures and treatment as they deem necessary. The doctors and staff of Primary PartnerCare Physicians, PLLC have made no guarantee of any particular result or outcome in connection with my care and treatment.

Patient Name (Please Print): _____

Signature of Patient or Patient's Authorized Representative: _____

Date: _____