PATIENT CENTERED CARE, PLL-C
PATIENT INFORMATION FORM

NAME (as shown on insurance card) _____ **DATE** _____

SOCIAL SECURITY NUMBER _____ **DATE OF BIRTH** ___/___/_____

ADDRESS _____ **RELIGION** _____

CITY _____ **STATE** _____ **ZIP** _____ **RELIGION** _____

OCCUPATION _____ **WORK PHONE** _____

EMPLOYER _____ **CELL PHONE** _____

EMAIL _____ **HOME PHONE** _____

** At which number may we leave a **BRIEF or EXTENDED** message?

RACE: African American Caucasian Hispanic Asian American Indian Alaska Native Pacific Islander Other _____ **Ethnicity**: Hispanic Non-Hispanic Other _____
Language: English Spanish Other _____

MARITAL STATUS _____ **SPOUSE/GUARDIAN NAME** _____

PREFERRED PHARMACY _____

PREFERRRED PROVIDER _____

IN CASE OF EMERGENCY, PLEASE CONTACT _____

RELATIONSHIP _____ **HOME#** _____ **WORK #** _____

WHO IS RESPONSIBLE FOR PATIENTS ACCOUNT? _____

ADDRESS _____ **HOME PHONE** _____

PRIMARY INSURANCE _____

POLICY HOLDER'S NAME _____ **RELATIONSHIP** _____

SECONDARY INSURANCE _____

POLICY HOLDER'S NAME _____ **RELATIONSHIP** _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

I request payment of authorized Medicare or other benefits be made on my behalf to Patient Centered Care, PLL-C for any services furnished to me by the medical provider. I authorize the release of medical information to the Health Care Financing Administration and its agents, including any information needed to determine these benefits or the benefits payable for related services.

I understand that all co-pays, deductibles or co-insurances are due at the time services are rendered unless prior arrangements have been made.

I understand that Patient Centered Care, PLL-C will mail a "Thank-you" to the person referring me to this practice.

SIGNATURE _____ **DATE** _____