PLUMTREE FAMILY HEALTH

Your demographic information is crucial to our ability to notify you concerning your medical care.
Please complete this form in its entirety.

Office Policies:

1. ***Any Co-pay not collected at the time of service will be assessed a $10.00 service fee.***
2. ***Patients who no show for scheduled appointments will be assessed a $25.00 service fee (History & Physicals are $50.00)***

PATIENT INFORMATION

Name:
Last First MI

Address: City: St: Zip:

Phone Numbers:
Home: Work: Cell:

Birthdate (mm/dd/yyyy)

Social Security Number

Marital Status: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Other

Sex: ❒ Male ❒ Female
*Certain tests are adjusted for this information.

Race: **Ethnicity**:______________

E-MAIL ADDRESS:

Preferred form of contact:

❒ Home # ❒ Cell # ❒ Text Cell # ❒ E-Mail

INSURANCE INFORMATION

PRIMARY INSURANCE NAME/TYPE (example: Blue Cross, Coventry, etc.):

Subscriber Name:
Last First MI

Insurance ID #	**Subscriber's Birthdate**:	**Relationship to Patient** :	Sex of Subscriber: ❒ Male ❒ Female

SECONDARY INSURANCE NAME:

Subscriber Name:
Last First MI

Insurance ID #	Subscriber's Birthdate:	Relationship to Patient :	Sex of Subscriber: ❒ Male ❒ Female

Name of Pharmacy: **Location:** **Phone#:**

PATIENT EMPLOYMENT OR SCHOOL INFORMATION

Employer Name: Occupation::

Student: ❒ Yes ❒ No School Name:

EMERGENCY INFORMATION- You may list more then one. Please add additional information on the back of the form.

Name: Relationship to Patient:

Home:
( )

Alternate Phone: Please specify (cell, work, etc.)
( )

RELEASE OF BENEFITS AND INFORMATION

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify your office of any and all changes to the above information. I authorize Plumtree Family Health Center to release any information required to process my claims with my insurance company.

Signature: Date:

Parent (if minor): Date: