ADVANCED FAMILY MEDICINE

Patient Information

Date _____ /_____ /_____

First Name:_____ Last Name:_____ Middle Initial:_____

Street Address:_____City:_____State:_____Zip:_____

Primary Phone:_____ Work Phone:_____Email:_____

Can we leave a message at your primary phone number regarding your medical care or test results? Yes No

Date of Birth:___/___/_____ Sex: Male Female Social Security #:_____

Marital Status: Married Single Divorced Seperated Widowed

Employer:_____Work Phone: _____

Responsible Party or Guardian (If patient is under 18)

First Name:_____ Last Name: _____ Relationship: _____

Address: _____City: _____ State:_____Zip:_____

Date of Birth: ____ /___/_____ Primary Phone:_____Email Address: _____

Emergency Contact (for all patients)

First Name:_____ Last Name: _____ Relationship: _____

Address: _____City: _____ State:_____Zip:_____

Date of Birth: ____ /___/_____ Primary Phone:_____Email Address: _____

Primary Insurance Information

Main Policy Holder Name:_____Address: _____

City:_____ State:___Zip:_____ Primary Phone:_____

Date of Birth: ____ /___/_____ Sex: Male Female Social Security #: _____

Email:_____ Patient relationship to insured: Self Spouce Child

Insured party (Main Policy Holder's) Employer:_____

Work Phone:_____

Insurance Company Name:_____Insurance ID #_____Group #_____

Consent to RX history □_____initials
Preferred Pharmacy Name and Location: _____ Phone:_____

Additional Patient Information

Ethnicity: Hispanic / Latino Not Hispanic / Latino Decline Race: Preferred Language

How did you hear about us? Family Friends Website Drive by Newspaper Other _____

Payment is due at time of service. AFM accepts cash, personal checks, Visa, Mastercard, Discover and debit cards.

I hereby authorize AFM to furnish insured's insurance company all information (including but not limited to HIV, sexually transmitted diseases, drug/alcohol abuse, mental illness or psychiatric treatment) which may be requested by them concerning my illness or injury. I also authorize the release of information regarding work related injuries to my employer.

By signing this document I recognize and acknowledge that I am completely responsible for all charges that I may incur at Advanced Family Medicine. I certify that all of the information provided above is current and accurate.

Patients Name / Responsible Party: (please print)_____

Patient Signature: _____ Date: _____

FOR MEDICARE PATIENTS ONLY

Annual Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me, or on my behalf to Advanced Family Medicine for any services furnished me by any Advanced Family Medicine healthcare professional. I authorize the holder of my medical information to release to the Health Care Financing Administration and its agents any information needed to determine the assignment of these benefits or the benefits payable for related services.

Annual Medigap Authorization

I request that payment of authorized Medigap benefits be made on my behalf to Advanced Family Medicine for any services furnished me by any Advanced Family Medicine healthcare professional. I authorize the holder of my medical information to release to the secondary insurance carrier any informa tion needed to determine the assignment of these benefits or the benefits payable for related services.

Printed Name of Beneficiary _____

Medicare Policy Number _____

Signature _____

Date _____