~2009~ Primary Care Associates
Affiliates of U.S. HealthWorks

PATIENT INFORMATION

Please Print

Date:_____

Patient: [ ] Adult [ ] Child

Full Name:_____ Birthdate:_____ Social Security #:_____
[ ] Male [ ] Female [ ] Married [ ] Single [ ] Other
Mailing Address:_____
City:_____ State:_____ Zip:_____
Home phone:_____ Work Phone:_____ Cell Phone:_____
Employer:_____Drivers License#:_____

Allergies: List medications and reactions:_____

Spouse/Significant Other/Parent Name :_____Social Security #:_____
(please circle appropriate)
Mailing Address:_____
City:_____ State:_____ Zip:_____
Home phone:_____ Work Phone:_____ Cell Phone:_____
Employer:_____

Person Responsible for Account :_____ Birthdate:_____
Address:_____
City:_____ State:_____ Zip:_____
Home phone:_____ Work Phone:_____ Cell Phone:_____
Employer:_____
Social Security Number:_____ Drivers License#:_____

Do you have medical Insurance? **[ ] Yes** **[ ] No**
If yes, please complete the next section.
This is Information that cannot necessarily be obtained from a Photocopy.

	Primary Insurance:	Secondary Insurance:
Person Policy Issued to:	_____	_____
Employer:	_____	_____
Name of Insurance Company:	_____	_____
Group Number:	_____	_____
Policy #/Employee #:	_____	_____
Birthdate:	_____	_____

(We need the above information so that we may help you obtain the medical insurance benefits if you are eligible. This may require submitting the Doctor's treatment plan to the insurance company(s) for a "pre-determination" of benefits or in some cases obtaining the information by phone. We can NEVER guarantee payment by your insurance company. The insurance company's contract is with you and your employer.)

Nearest relative or friend not living with you :_____ Phone:_____

In case of emergency notify :_____ Phone:_____

Patient or Guardian Signature:_____ Date:_____

Any Subsequent Insurance Changes must be Provided Prior to Any Office Visit ~Or~ Lab Testing. Thank You!