Welcome to PARIS FAMILY PHYSICIANS,PA **DATE:_____**

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print.

Patient Legal Name _____ Any other name used_____
FIRST MI LAST

CONTACT PREFERENCE for reminders: (check one) Text ___ Voice Call ___

Email address _____ **Cell phone** _____

Address _____ City & State _____ Zip_____ Home phone_____

Employer _____ Work Phone_____

SSN _____ Birthdate _____ Sex _____M _____F Marital Status _____

Race (check one): __American Indian or Alaska Native __Asian __Black __White __Native Hawaiian __Other

Ethnicity (check one): __Hispanic or Latino __Not Hispanic or Latino Preferred Language _____

Spouse or parent's name _____ Employer _____ Work phone _____

Person to contact in case of emergency: _____ **Phone:** _____

RESPONSIBLE PARTY: (*if different from patient information above*)

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Phone _____

Work phone _____ SSN _____ Birthdate _____

***Provide copy of insurance card**

***PRIMARY INSURANCE NAME*:** _____

INSURED PERSON'S NAME: _____ **DOB:** _____ **ID NUMBER:** _____

***SECONDARY INSURANCE NAME*:** _____ **(if applicable)**

INSURED PERSON'S NAME: _____ **DOB:** _____ **ID NUMBER:** _____

FAMILY MEMBERS WHO ARE PATIENTS OF PARIS FAMILY PHYSICIANS:

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

ASSIGNMENT OF BENEFITS:

I authorize all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Paris Family Physicians. This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Paris Family Physicians to release all information necessary to secure payment.

_____ _____

Signature of Patient or legal representative **Date**

****Minors require Parent or Legal Representative completion**