PATIENT INFORMATION

NAME: (last)_____(first)_____

(Middle)_____(SS#)_____

ADDRESS: _____

(City)_____(state)_____(zip code)_____

PHONE: _____(CELL PHONE #)_____EMAIL:_____

DATE OF BIRTH: _____(sex) Male_____ Female____ **Race:** Asian___ Black___ Hispanic___ White___
Language: English___ Other___ Sign language___ Spanish___
Ethnicity: Latino : YES___ NO___

MARITAL STATUS: Single____ Married____ Widowed____ Divorced____

EMPLOYER: _____ Phone #: _____

PHARMACY: _____(phone #)_____

EMERGENCY CONTACT:(name)_____Relationship_____

Phone #)_____

GUARANTOR/RESPONSIBLE PARTY **(if same, write same as above)**
PRIMARY
SUBSCRIBER'S INFO: **(whose name insurance is in)**

NAME: _____SS#_____

RELATIONSHIP: _____**Sub. D.O.B.** _____

ADDRESS: _____

(City)_____(state)_____SUBSCRIBER'S PHONE #_____

SECONDARY
SUBSCRIBER'S INFO.
NAME: _____SS# _____

RELATIONSHIP: _____**Sub. D.O.B.** _____

ADDRESS: _____

(City) _____(state) _____

IS THIS VISIT RELATED TO AN INJURY NO _____ YES _____ AUTO _____ WORK _____

I assign all medical benefits to which I am entitled to TOTAL PATIENT CARE, LLC. I understand that I am financially responsible for any charges incurred that are not covered by my insurance. I authorize said assignee to release any information needed to determine these benefits payable for related services.

Patient signature _____Date _____