LIBERTY FAMILY MEDICINE LLC

PATIENT INFORMATION

PERSONAL INFORMATION:

NAME: MR. / MRS. / MS. / FR. / SR. / JR.

FIRST MI LAST

ADDRESS

CITY STATE ZIP

HOME PHONE CELL PHONE WORK PHONE

SEX: M F

BIRTHDATE SOCIAL SECURITY # MARITAL STATUS

EMPLOYER OCCUPATION

EMERGENCY CONTACT PERSON PHONE NUMBER

IF THE PATIENT IS A MINOR: (18 OR YOUNGER)

MOTHER/GUARDIAN'S NAME

ADDRESS *(If same as above, please write "same")*

CITY STATE ZIP

HOME PHONE WORK PHONE

FATHER/GUARDIAN'S NAME

ADDRESS *(If same as above, please write "same")*

CITY STATE ZIP

HOME PHONE WORK PHONE

May we provide non custodial parent with info? Y N

CHILD LIVES WITH

PRIMARY INSURANCE INFORMATION:

NAME OF PRIMARY INSURANCE COMPANY

SUBSCRIBER NAME SEX: M F

D.O.B. SOCIAL SECURITY # RELATIONSHIP

EMPLOYER NAME EFFECTIVE DATE

MEMBER ID # GROUP #

SECONDARY INSURANCE INFORMATION:

NAME OF PRIMARY INSURANCE COMPANY

SUBSCRIBER NAME SEX: M F

D.O.B. SOCIAL SECURITY # RELATIONSHIP

EMPLOYER NAME EFFECTIVE DATE

MEMBER ID # GROUP #

I hereby authorize the release of information regarding services rendered by Liberty Family Medicine LLC and allow a photocopy of my signature to be used to file insurance. I direct my carrier to issue payment for benefits directly to Liberty Family Medicine LLC.

Signature:____ Date:___________________ _____