

# PALMER FAMILY MEDICINE

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ M/F \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Residence/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security \_\_\_\_\_  
Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced/Separated \_\_\_\_\_ Widowed \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
May we call you at work? Yes/No

## RESPONSIBLE PARTY

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ M/F \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Residence/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

## INSURANCE INFORMATION

**Primary** Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Insured \_\_\_\_\_ DOB \_\_\_\_\_ Social Security # \_\_\_\_\_  
**Secondary** Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Insured \_\_\_\_\_ DOB \_\_\_\_\_ Social Security # \_\_\_\_\_

## GENERAL INFORMATION

Person to contact if unable to reach patient (not living in your home)  
Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
Who referred you to our office? \_\_\_\_\_ Preferred Pharmacy \_\_\_\_\_  
With whom in your family may we discuss your health care? \_\_\_\_\_

I hereby assign all medical and or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, PPO plans, Medicaid, RR Medicare, and all other health plans to Palmer Family Medicine, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance (including Medicaid). I hereby authorize said assignee to release all information needed to secure the payment.

Signed \_\_\_\_\_ Date \_\_\_\_\_