Central Primary Care

PLEASE PRINT

DATE: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (___)_____ ALTERNATIVE PHONE: (___)_____

BIRTHDATE: _____ AGE: ____ GENDER: ___SOCIAL SECURITY _____

REFERRED BY: _____

EMERGENCY CONTACT: _____ PHONE: (___)_____

RELATION TO PATIENT: _____ MARITAL STATUS: _____

EMPLOYER: _____ PHONE: (___)_____

ADDRESS: _____

PRIMARY INSURANCE: _____

CLAIMS ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

ADDITIONAL INSURANCE INFORMATION:

It is customary to pay for services when rendered unless other arrangements have been made with our office.

Authorization to release information: I hereby authorize release of any medical information necessary in the course of treatment. I also hereby authorize any payment for medical services provided to be made directly to the physician.

Date: _____ Patient's signature: _____