FACEY MEDICAL GROUP MEDICAL INFORMATION SHEET

EMRN: ___________

PLEASE PRINT CLEARLY DATE: ______________________________

PATIENT NAME ______________________________ PCP (Primary Care Physician): ______________________________

AKA (also known as): ______________________________ D.O.B. ______________________

SSN#: ____________________ SEX: Female ☐ Male ☐ MARITAL STATUS: S ☐ M ☐ SEP ☐ D ☐ W ☐

HOME ADDRESS: ____

CITY/STATE/ZIP CODE: ____

HOME PHONE #: ______________________________ WORK PHONE #: ______________________________

DAYTIME/CELL PHONE # ______________________________ EXT #: ______________________________

EMPLOYER NAME: ______________________________ OCCUPATION: ______________________________

EMPLOYER ADDRESS: CITY/STATE/ZIP CODE:

ETHNICITY: (Select one)

☐ Hispanic/Latin/Spanish Origin
☐ NOT Hispanic/Latin/Spanish Origin
☐ Decline

RACE: (Select one)

☐ American Indian/Alaskan Native ☐ Hispanic/Latino
☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White ☐ Decline

PREFERRED METHOD OF COMMUNICATION: (Select one)

☐ Telephone ☐ Mail ☐ Decline

PERSON RESPONSIBLE FOR PATIENT'S FINANCIAL OBLIGATION, IF SELF, INDICATE SELF

NAME: ______________________________

RELATIONSHIP: ______________________ SS#: ______________________ DOB: ______________________

HOME PHONE: ______________________ WORK PHONE #: ______________________ EXT: ______________

DAYTIME/CELL PHONE #: ______________________ EXT: ______________

HOME ADDRESS (If different from Patient's address): ______________________________

CITY/STATE/ZIP CODE: ____

EMPLOYER NAME: ______________________________ CITY/STATE/ZIP CODE: ______________________________

IN CASE OF EMERGENCY - NAME OF RELATIVE NOT LIVING WITH YOU (Local)

PRIMARY CONTACT NAME: ______________________________ RELATIONSHIP: ______________________________

HOME PHONE #: ______________________ WORK PHONE #: ______________________ EXT: ______________

DAYTIME/CELL PHONE #: ______________________ EXT: ______________

HOME ADDRESS: ______________________ CITY/STATE/ZIP CODE: ______________________

SECONDARY CONTACT NAME: ______________________________ RELATIONSHIP: ______________________________

HOME PHONE #: ______________________ WORK PHONE #: ______________________ EXT: ______________

DAYTIME/CELL PHONE #: ______________________ EXT: ______________

HOME ADDRESS: ______________________ CITY/STATE/ZIP CODE: ______________________

PATIENT INSURANCE INFORMATION DO YOU HAVE HEALTH INSURANCE? YES ☐ NO ☐

PRIMARY INSURANCE

INSURANCE CO: ______________________
INSURANCE PHONE #: ______________________
SUBSCRIBER: ______________________
SUBSCRIBER'S EMPLOYER NAME: ______________________
SUBSCRIBER'S DATE OF BIRTH: ______________________
SUBSCRIBER'S SSN #: ______________________
POLICY # ______________________
GROUP # ______________________
EFFECTIVE DATE: ______________________

SECONDARY INSURANCE

INSURANCE CO: ______________________
INSURANCE PHONE #: ______________________
SUBSCRIBER: ______________________
SUBSCRIBER'S EMPLOYER NAME: ______________________
SUBSCRIBER'S DATE OF BIRTH: ______________________
SUBSCRIBER'S SSN #: ______________________
POLICY #: ______________________
GROUP #: ______________________
EFFECTIVE DATE: ______________________

ASSIGNMENT OF BENEFITS

I hereby authorize and direct my insurance company to make payments to FACEY MEDICAL FOUNDATION, benefits allowable and otherwise payable to me and/or my dependents. I understand that I am responsible for charges not paid under this Assignment. This Authorization will remain in effect until rescinded by myself in writing. A photocopy of this Assignment may be honored.

PATIENT'S SIGNATURE: ______________________________ DATE: ______________________

WITNESS' SIGNATURE: ______________________________ DATE: ______________________