

# FACEY MEDICAL GROUP MEDICAL INFORMATION SHEET

EMRN: _____
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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) <input type="checkbox"/> Hispanic/Latin/Spanish Origin <input type="checkbox"/> NOT Hispanic/Latin/Spanish Origin <input type="checkbox"/> Decline	RACE: (Select one) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Decline
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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

<u>PRIMARY INSURANCE</u> INSURANCE CO: _____ INSURANCE PHONE #: _____ SUBSCRIBER: _____ SUBSCRIBER'S EMPLOYER NAME: _____ SUBSCRIBER'S DATE OF BIRTH: _____ SUBSCRIBER'S SSN #: _____ POLICY #: _____ GROUP #: _____ EFFECTIVE DATE: _____	<u>SECONDARY INSURANCE</u> INSURANCE CO: _____ INSURANCE PHONE #: _____ SUBSCRIBER: _____ SUBSCRIBER'S EMPLOYER NAME: _____ SUBSCRIBER'S DATE OF BIRTH: _____ SUBSCRIBER'S SSN #: _____ POLICY #: _____ GROUP #: _____ EFFECTIVE DATE: _____
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## 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: \_\_\_\_\_