Overlake Family Medicine

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Date: _____

PATIENT INFORMATION				
Last Name			First Name	Initial
Address				
Home Phone:			Mobile Phone:	
Sex M F	Birth date	Age	☐ Single ☐ Married ☐ Widowed ☐ Divorced	Soc. Sec. No.
Employer/School: Status ☐ Full time ☐ Part time				
Employer:			Occupation:	
Business Address:			Business Phone:	

Spouse's Name:	Business Phone:	Mobile Phone:
Who to notify in case of an emergency? (Name & Phone #)		
Who referred you to this practice?		
Have you been known by a different name?		

MEDICAL INSURANCE: (Please present your insurance cards to be copied)		
Responsible Person for this account (if other than patient):		Relationship to Patient:
Subscribers Phone:	Subscribers birthdate	Subscribers soc. sec. no.

Primary Insurance:	Name of Insured:	Group / Member #
Secondary Insurance:	Name of Insured:	Group / Member #

I hereby authorize this physician's office to release any information necessary to secure the payment of benefits. While we will assist with billing your insurance company, you are primarily responsible for determining what your insurance will cover, whether you require a referral, and/or the payment of your bill.

I understand that I am financially responsible for all charges whether or not paid by said insurance.

Date:_____ Patient Signature:_____

Guardian Signature: _____

REORDER # 04-24601