

PATIENT INFORMATION

FIRST NAME _____
 LAST NAME _____ MID INTIAL _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 HOME PHONE _____
 WORK/CELL PHONE _____
 AGE _____ DATE OF BIRTH _____
 Social Security # _____
 SEX M / F / T MARITAL STATUS S M W D SEPERATED
 E-MAIL ADDRESS _____

Preferred Method of Communication

E-mail Cell Phone Home Phone Work Phone Decline

EMPLOYER _____
 PRIMARY PHYSICIAN _____
 REFERRED BY _____

Please circle one of the following

ETHNICITY:
Hispanic /Latino Non- Hispanic /Latino Decline to Answer
 RACE:
Am. Indian/Alsaka Native Asian Black or African American
Native Hawaiian / Other Pacific Islander White Decline to Answer

PREFERRED LANGUAGE: _____

SMOKING STATUS: (Circle) Yes No

If yes, how many a day? _____
Are you a *Former Smoker*? Yes No When did you quit? _____

PARENT or SPOUSE *(Must complete if Insurance is through a parent or spouse.)*

NAME _____
 RELATIONSHIP _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 CELL PHONE _____
 WORK PHONE _____
 SOCIAL SECURITY # _____
(Must complete if Insurance is through a parent or spouse.)
 DATE OF BIRTH _____ SEX (Circle) Male Female
 EMPLOYER _____

IN CASE OF AN EMERGENCY OR NEXT OF KIN

Please Provide Address if different than patient.
 NAME _____
 RELATIONSHIP _____
 PHONE # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

I am insured through: (Circle) SELF JOB SPOUSE PARENT

PRIMARY INSURANCE

Insurance Company Name _____
 Name on Primary Insurance Card _____
 ID# (Subscriber or member #) _____
 GROUP # _____
 Specialist Copay _____ Effective Date _____

SECONDARY INSURANCE

Insurance Company Name _____
 Name on Secondary Insurance Card _____
 ID# (Subscriber or member #) _____
 GROUP# _____
 Specialist Copay _____ Effective Date _____

TERTIRAY INSURANCE

Insurance Company Name _____
 Name on Secondary Insurance Card _____
 ID# (Subscriber or member #) _____
 GROUP# _____
 Specialist Copay _____ Effective Date _____

RELEASE OF INFORMATION:

() YES () NO

I hereby authorize release of information for insurance claim purposes, transfer of care from one facility to the my current facility or vice versa, release for personal, family, work or other information. The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV/Aids and Zika.

I understand all of the above and hereby state that the information is correct to the best of my knowledge. I also understand that CSFHC does not provide care for Worker's Compensation. After 45 days any balance not paid for by insurance becomes the patient balance and due immediately. I also agree to pay a \$5 monthly billing fee for balances over 30 days old and a \$10 monthly billing fee for balances over sixty days old. If my delinquent balance gets turned over to an outside collections agency I understand a collections fee of 35% will be added to my current balance.

Signed _____ Date _____

(Responsible Person or Parent/Guardian if minor)