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 SEP**

□ **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. Also, 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.

Signed_____**Date**_____

(Responsible Person or Parent/Guardian if minor)