NavicentHealth Physician Group
Patient Information Form

PATIENT INFORMATION

Today's date _____ **Referring Physician** _____ **Primary Physician** _____

Patient Name _____
First *Middle* *Last*

Date of Birth _____ Social Security Number _____ □ Male □ Female

Address _____

City _____ State _____ Zip _____

Phone Number _____
Home ***Cell*** ***Work***

Email Address _____

Race (Circle) Asian, American Indian, African American, White, Hispanic, Other **Primary Language (Circle)** English, Spanish, Indian, Other **Ethnicity (Circle)** Hispanic, Non-Hispanic, Refused to Report

RESPONSIBLE PARTY

_____
First *Middle* *Last*

Date of Birth _____ Social Security Number _____ □Male □Female

Employer Name _____ Employer Number _____

Employer Address _____
City *State* *Zip*

Phone Number _____
Home ***Cell*** ***Work***

EMERGENCY CONTACT

1) Name _____ Ph. Number _____ Relationship _____

2) Name _____ Ph. Number _____ Relationship _____

INSURANCE INFORMATION: PLEASE PROVIDE COPIES OF ALL MEDICAL INSURANCE CARDS

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Carrier Name	*Insurance Carrier Name*
Policy Number *Group Number*	*Policy Number* *Group Number*
Claims Mailing Address _____ *Phone Number*	*Claims Mailing Address* _____ *Phone Number*
Cardholder's Name _____ *Cardholder's SSN* *DOB*	*Cardholder's Name* _____ *Cardholder's SSN* *DOB*
Cardholder's Employer	*Cardholder's Employer*

INCIDENT INFORMATION

If you plan to file other insurance please provide supporting documentation

□ **Workers Compensation** □ **Liability** □ **Auto Insurance** □ **No Auto Coverage**

RELEASE OF PROTECTED HEALTH INFORMATION

Unless you give written permission we will not release you medical information according to the HIPPA guidelines. If you have someone who you want us to release your protected health information to such as a spouse, child, or parent please list (please note if you are requesting the release of medical records you will have to complete a Release of Information Form as this will only authorizes verbal communication):

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Signature of Patient, Parent or Guardian: _____ Date