

Patient Information

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms		Last Name	First Name	Initial	Date of Birth
Address		City		Zip	Home Phone
Driver's License #		Social Security #		Age	Cell Phone
Place of Employment					
Business Address		City	Zip	Work Phone	
Name of Person we may contact in the event of an emergency					Phone #
Spouse's Name / Parents Name (if a minor)			Relationship		
Name of Primary Insurance Coverage			Secondary of Supplemental Insurance Coverage		
Subscriber ID#			Subscriber ID#		
Group #			Group#		
Subscriber Name:			Subscriber Name		
Subscribers Employer			Subscribers Employer		

Please provide copies of your insurance cards so we can make copies for our records

I request that payment of authorized Medicare or other insurance benefits to be paid on my behalf to Redlands Family Practice, Inc., for any services furnished to me by this physician/supplier. I authorize any holder of medical information and its agents to provide any information needed to determine these benefits payable for related services. I understand that I am financially responsible for all charges not covered by the insurance coverage and this authorization (A copy of this assignment as valid as the original).

I authorize Redlands Family Practice and its representatives to access my prescription history available through my prescription benefit plan.

Signature of Patient (or responsible party)

Date

Print Name

Admin Use Only: Scanned _____
