BELLBROOK FAMILY PRACTICE

DATE: _____

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

SS#: _____ SEX: _____ MARITAL STATUS: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: _____

Is this your billing address as well? Yes____ No____ If no, please provide address: _____

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ WORK PHONE: _____

INSURANCE INFORMATION

Please present your insurance card and driver's license for us to make copies.

PRIMARY INSURANCE: _____ ADDRESS:: _____

ID#: _____ GROUP #: _____ PLAN #: _____

SUBSCRIBER'S NAME _____ DATE OF BIRTH: _____ :

SUBSCRIBER'S SS#: _____ RELATIONSHIP TO PATIENT: _____

EFFECTIVE DATE: _____ AMOUNT OF COPAY: _____

SECONDARY INSURANCE: _____ ADDRESS:: _____

ID#: _____ GROUP #: _____ PLAN #: _____

SUBSCRIBER'S NAME _____ DATE OF BIRTH: _____ :

SUBSCRIBER'S SS#: _____ RELATIONSHIP TO PATIENT: _____

EFFECTIVE DATE: _____ AMOUNT OF COPAY: _____

CONTACT INFORMATION

Preferred phone number for contacting you about appointment or results: _____

A message may be left at my home Yes _____ No _____

A message may be left at my place of employment Yes _____ No _____

A message may be left on my voice mail Yes _____ No _____

Bellbrook Family Practice staff or physicians may be identified as the caller Yes _____ No _____

EMERGENCY CONTACT: _____ PHONE: _____ Relationship _____

MINOR / GUARDIAN INFORMATION

IF PATIENT IS A MINOR, LEGAL GUARDIAN'S NAME:: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

GUARDIANSHIP AUTHORIZATION: I give _____ my permission bring my child,

_____ , to Bellbrook Family Practice for medical care / treatment.

_____ (signature of parent)

I give Bellbrook Family Practice my permission to evaluate and treat my child, _____ ,

in my absence. _____ (signature of parent)

PLEASE COMPLETE BACK OF FORM

AUTHORIZATIONS

- **YOU HAVE MY PERMISSION TO DISCUSS MY MEDICAL RECORD INFORMATION AND ACCOUNT WITH THE FOLLOWING FAMILY PERSONS: _____**

  _____

- **I hereby authorize Bellbrook Family Practice to apply for benefits on my behalf for covered services rendered by the physicians or their orders, realizing that I am responsible to pay for my medical services. I request that payment from my insurance company be made directly to the physician.**

- **I hereby authorize the release of any pertinent medical information to insurance carriers from consulting physicians.**

- **I hereby authorize Bellbrook Family Practice to release pertinent medical information to consulting physicians.**

- **I certify that the information I have reported with regard to my insurance company is correct. Either my insurance company or I may revoke this authorization at any time in writing.**

- **I permit a copy of any of these authorizations to be used in place of the original.**

Signature: _____ Date: _____

(Patient / Legal Guardian)