FIRST CHOICE MEDICAL CARE, PLLC

PATIENT INFORMATION

(Please fill out completely.)

Date: _____

First Name: _____ Last Name: _____ Date of Birth: _____

Sex: M or F (circle one) Marital Status: Single Married Divorced Widowed Other _____ (circle one)

Address: _____ City: _____ State: ____ Zip Code: _____

Primary Phone # _____ Cell Phone #: _____ Social Security #: _____

Emergency Contact: _____ Phone #: _____
(not living with you)

Email address: _____

Employer: _____ Work Phone # _____

Employer Address: _____

Pharmacy: _____ Pharmacy Phone #: _____

SPOUSE/PARENT INFORMATION

(Please fill out completely.)

Spouse/Parent: _____ Date of Birth: _____ Social Security #: _____

Address (if different than above): _____ City: _____ State: ___ Zip: _____

Employer: _____ Employer Address: _____

City, State, Zip: _____ Work Phone #: _____

INSURANCE INFORMATION

(Cards Must Be Provided at Check-IN.)

Primary Insurance: _____ Effective Date: _____

Insured's Name: _____ Date of Birth of Insured: _____
(if not self)

Secondary Insurance: _____ Effective Date: _____

Insured's Name: _____ Date of Birth of Insured: _____
(if not self)

I hereby authorize First Choice Medical Care, PLLC to bill the insurance provided for services provided and to release my medical information about me or my dependent to my insurance company to determine the benefits or the benefits payable for related services. I understand I am financially responsible for all charges, whether or not covered by said insurance. This assignment will remain in effect until revoked by me in writing.

Patient/Guarantor's Signature: _____ Date: _____