

# 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 #: \_\_\_\_\_

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## 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 #: \_\_\_\_\_

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## 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)

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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: \_\_\_\_\_