MERCED FACULTY ASSOCIATES MEDICAL GROUP

PATIENT INFORMATION FORM

PATIENT INFORMATION

Date: Primary Physician: Home Phone: Cell Phone:

Name: Soc. Sec. #:

Address: Driver Lic. #: _____

City: State: Zip:

Sex: Age: Birthdate: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Language: Race: . Ethnicity:

Email: Contact Preference:

Patient Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Whom may we thank for referring you? _____

In case of emergency who should be notified?: Phone:

PRIMARY INSURANCE

Person Responsible for Account: _____

Relation to Patient: _____ Birthdate:_____ Sco. Sec. #:_____

Subscriber Name:

Subscriber Address:

Address (if different from patient's): Phone: _____

City: State: Zip:

Person Responsible Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company:

Contact#: _____ Group #: _____ Subscriber #: _____

Name of other dependents covered under this plan: _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name: Relation to Patient: _____ Phone: _____

Subscriber Address: , ,

Address (if different from patient's): Phone: _____

City: State: Zip:

Subscriber Employed by: _____ Business Phone: _____

Insurance Company: Soc. Sec. #: _____

Contact#: _____ Group #: _____ Subscriber #: _____

Name of other dependents covered under this plan: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____

Name of Insurance Company(ies)

and assign directly to MERCED FACULTY ASSOCIATES all insurance benefits, if any, otherwise payable to me, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize treatment by MERCED FACULTY ASSOCIATES MEDICAL GROUP.

_____ Responsible Party Signature

_____ Relationship

_____ Date